South Carolina Medicaid Managed Care Program

Policy and Procedures Guide

for

MEDICAL HOMES NETWORK

April 1, 2010

TABLE OF CONTENTS

MEDICAL HOMES NETWORK PROGRAM

INTRODUCTION

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XIX of the Social Security Act known as the Medicaid Program. The United States Department of Health and Human Services allocated funds under Title XIX to the SCDHHS for the provision of medical services for eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

The South Carolina Department of Health and Human Services (SCDHHS) has defined its mission as providing statewide leadership to most effectively utilize resources to promote the health and well being of South Carolinians. The State intends to promote and further its mission by defining measurable results that will improve member access and satisfaction, maximize program efficiency, effectiveness, and responsiveness, and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a medical home for Medicaid beneficiaries to promote continuity of care.
- Emphasize prevention and self-management to improve quality of life.
- Supply providers and members with evidence-based information and resources to support optimal health management.
- Utilize data management and feedback to improve health outcomes for the state.

The establishment of a medical home for all Medicaid eligible beneficiaries has been a priority/goal of the SCDHHS for a number of years. The goals of a medical home include:

- Accessible, comprehensive, family centered, coordinated care.
- A medical home with a provider to manage the patient's health care, to perform primary and preventive care services and to arrange for any additional needed care.
- Patient access to a "live voice" 24 hours a day, 7 days a week to ensure appropriate care.
- Patient education regarding preventive and primary health care, utilization of the medical home and appropriate use of the emergency room.

SCDHHS has initiated Medicaid medical homes programs through networks of primary care providers - Medical Homes Networks (MHN). MHN is Medicaid's Primary Care Case Management (PCCM) program linking Medicaid beneficiaries with a primary care provider (PCP). The PCP works in partnership with the member to provide and arrange for most of the member's health care needs. The outcomes of this medical home initiative has been healthier, better-educated Medicaid beneficiaries and cost savings for South Carolina through a reduction of acute medical care and disease related conditions.

MHN members have care managers who assist in developing, implementing, and evaluating the care management strategies of the Network. These care management strategies include:

- Risk assessment process – utilizing an "at risk" screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by members.
- Implementing disease management processes – for example, targeting pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those members at risk.
- Identifying high costs and high users – developing and implementing activities that impact utilization and cost.

The purpose of this guide is to document the medical and program policies and requirements implemented by the SCDHHS for Medical Homes Networks (MHN) wishing to conduct business in South Carolina.

The Department of Managed Care, located within the Division of Care Management, Bureau of Care Management and Medical Support Services, is responsible for the formulation of medical and program policy, interpretation of these policies and oversight of quality and utilization management requirements set forth in this chapter. MHNs in need of assistance to locate, clarify, or interpret medical or program policy should contact the Department of Managed Care at the following address:

Department of Managed Care
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: (803) 255-8232
Phone: (803) 898-4614

Requests to add, modify or delete standards, criteria or requirements related to current medical or program policy should be forwarded to the Department of Managed Care.

THE CONTRACT PROCESS

This section will provide the information necessary for preparing to initiate a Medical Homes Network (MHN) contract with the SCDHHS. SCDHHS will furnish potential MHNs with a copy of the MHN standards, the Policy and Procedure Guide and the model contract upon, request. This contract may also be found on the SCDHHS website at www.scdhhs.gov. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a contract with any qualified Network that meets the SCDHHS standards for Medical Homes Networks. SCDHHS will contract with a Medical Homes Network through the Care Coordination Service Organization (CSO). SCDHHS will not contract with any individual and/or group of individuals having an outstanding debt with the agency. If any member of a group has an outstanding debt against SCDHHS, the entire group will be considered to have same. South Carolina also will not contract with any group or individual who are on the USDHHS exclusion list.

The potential MHN should send a letter requesting consideration for participation in the MHN program. The letter should include a statement of purpose, brief company background to include ownership, corporate status, major shareholders and/or company officers, location of network, basic Network structure, and the name of the primary contact. The letter should be addressed to:

Director, Division of Care Management
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Upon receipt of this letter, SCDHHS will provide the applicant details on the application process, including an overview of the MHN standards. The applicant should prepare a thorough written response to demonstrate their ability to meet each standard /deliverable. This becomes the potential contractor's official application packet and should be addressed to:

Director, Division of Care Management
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

The Department of Managed Care will convene a team to review the **Application Packet**. SCDHHS will notify the applicant of any changes or re-submissions that must be made prior to approval. Concurrent to this review process, the MHN will coordinate with the SCDHHS Division of MMIS to establish connectivity with SCDHHS information systems.

Once the Application Packet has been approved, SCDHHS will mail an **Enrollment Package** to the applicant. The Enrollment package will contain the following:

1. Two (2) copies of the contract
2. Enrollment Form (SCDHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership and Controlling Interest Statement Form SCDHHS 1513 (02/09)
5. Form W-9, Taxpayer Identification Number and Certification
6. Drug Free Workplace Form
7. EFT Authorization Form
8. Certification Relating to Restrictions on Lobbying
9. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower tier Covered Transactions
10. Nonresident Taxpayer Registration Affidavit

The potential MHN should then sign and return both copies of the Contract. Upon approval of all submissions and the establishment of connectivity SCDHHS will authorize its External Quality Review Organization (EQRO) to conduct an on-site **Readiness Review** of the MHN's South Carolina operation. If deficiencies are noted during the Readiness Review, the MHN must submit a Plan of Correction (PoC) to SCDHHS. The time frames given for correcting the deficiencies will be based on the severity and scope of the deficiencies. The SCDHHS staff will monitor the MHN's progress with its PoC. The purpose of this Readiness Review is to assess the MHN's capacity to begin immediate operations. The MHN is scored against a set of standards that represent SCDHHS' expectations for successful operation within the South Carolina Medicaid Program.

Once the Readiness Review has been completed and the EQRO has submitted its final report to SCDHHS attesting to the MHN's operational readiness, the SCDHHS Managed Care staff will submit contract for **CMS approval**. Upon receiving approval from CMS, the appropriate paper work to enroll the MHN in the MMIS system will be submitted.

The Managed Care staff will review and approve the basic boilerplate contract(s) used to contract with primary care physicians. Staff will also review contracts with any other subcontractor to ensure state and federal requirements are met. SCDHHS will review and approve networks submitted by the MHN and determine network adequacy. Along with the county provider submission, the MHN will provide an attestation that all provider contracts are in compliance with the following state requirements:

- All contracts and amendments have been reviewed and approved by SCDHHS,
- All contracts have been properly signed,
- All contracts include approved hold harmless language,
- All contracts cover the services specified in the county provider submission,

- All contracts (as appropriate) contain suitable documentation regarding hospital privileges, credentialing information and a listing of group practice members.
- All contracts are at a minimum one year (12 months) in term with the option to renew after the first term for maximum of five (5) years.

Subcontracts for PCPs

MHN subcontracts with PCPs must be for a period of at least 12 months (one year). SCDHHS will not accept Letters of Agreement (LOA), Memorandum of Understanding (MOU) or any variations of these types of agreements.

The "MHN Reports to SCDHHS" section of the Policy and Procedures Guide contains the Network Provider and Subcontractor Listing Spreadsheet Requirements as well as the Model MHN Attestation Form. The MHN contract with SCDHHS details all the provisions which must be included in subcontracts with providers.

Activities and Potential Time Frames

- Review of Application Packet — Up to 120 days
- Interface with SCDHHS IT Systems (concurrent with above) — Up to 120 days
- Review of Enrollment Package — Up to 30 days
- Readiness Review (not including scheduling time of 2-3 weeks) — 2 to 3 days
- Readiness Review Report Completed — Within 30 days of site visit
- Review of Contract by CMS — Up to 45 days
- Network Adequacy Desk Review — Submitted upon passing of Readiness Review
- Network Approval — Up to 15 Days
- Sign-up/assignment of members — Within 10 days following Network Approval
- Enrollment of members — ASAP

THE MEDICAL HOMES NETWORK

The Medical Homes Network and Care Coordination Service Organization

The Network shall be defined as the participating physician practices and the Care Coordination Service Organizations (CSO). If the network is geographically based, it should be comprised of the normal practice and referral patterns. MHNs are not exclusive and networks cannot prevent providers from participating in other managed care programs; i.e., MCO/PPO etc. If the network is specialty based, it should be comprised of similar types of providers, i.e., Children's Hospitals and their accompanying pediatric practices.

The CSO shall be the designated agent for the Network and provide both infrastructure and support to the Network and the participating primary care practices.

The CSO should be experienced, responsive, responsible, and financially sound.

The Network will receive a prospective payment. The expenses or costs of operating the Network are to be paid out of the generated cost savings. The prospective payment is a Per Member Per Month Care Coordination/Management fee that is based on the number of enrolled members. The payment is prospective in that it is an advance against the Network's anticipated savings. Thus the Network may be required to pay back a portion, if not all, of this advanced payment if the Network does not generate savings. This is the only payment that DHHS will make. Any PMPM paid to the participating physicians must come out of this payment, as must operating costs. The only limit DHHS will put on how the Network spends the money will be the limitations/restrictions attached to Federal funds. The Network must submit its Physician PMPM formula and its shared savings formula to DHHS for approval. The Network will also be required to submit a cost report at the end of each contract year to account for how the money was spent.

The State shall share documented cost savings with the network utilizing an agreed-upon formula established by independent actuaries contracted by the State. The CSO will be responsible for distributing the Network's share between the participating practices and the CSO, based upon the agreement established between the CSO and the practices. In the event a CSO terminates its contract with SCDHHS, it must allow its network providers to terminate their contract with the CSO, in accordance with the terms of their contract. The CSO may not withhold cost sharing payment if a provider terminates under these above-mentioned circumstances.

The Network and CSO will be responsible for components and services as follows:

- Care Coordination and Case Management.
- Service Referral Management
- Tracking of services provided to members
- Member Education.

- Disease Management.
- Provider Education and training on evidence-based medicine
- Pharmacy Management to include, but not limited to: Benefit Management Oversight and Clinical Risk Identification.
- Exception and performance tracking and reporting.
- Outcomes measurement and data feedback.
- Distribution of the Per Member Per Month care coordination fee to participating physicians using a SCDHHS approved incentive based formula.
- Distribution of cost savings.

The Scope of Work the CSO is expected to perform consists of these components:

Development, maintenance and expansion of a network of physicians that will assume responsibility for providing medical homes for Medicaid beneficiaries in their respective service areas. The CSO is expected to provide a sufficiently developed infrastructure to support the member practices in the management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner. This infrastructure should include, at a minimum:

1. A comprehensive care coordination protocol including:
    - Care coordination staffing, standards and support
    - Methodology for defining which patients will receive care coordination services (patients who are considered "high utilizers" and/or non-compliant must be targeted for care coordination)
    - Procedures to follow up with patients admitted to the hospital, seen at the emergency room, or receiving extended medical care

2. Administrative and information technology mechanisms and systems to support the CSO, physician network and state/federal mandates

3. Disease Management initiatives

4. A system of pharmacy utilization review

5. A professionally staffed all service/Help Line/Nurse Line which operates 24 hours per day, 7 days per week

6. The ability to document and demonstrate budget neutrality or cost savings for services to beneficiaries in the plan

7. A management system that ensures the identification of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner

8. A system of monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment, including externally referred services

9. Assurance that the participating PCPs perform the following duties and meet the standards listed below:

   A. Provide primary care and patient care coordination services to each member.
   B. Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day/seven (7) days per week.
   C. Provide prompt access (within one hour) to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service, when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours. (Use of an automated system to answer the phone is acceptable as long as patients are able to access a live person through one of the automated options.)
   D. Provide members with an after-hours telephone number. The after-hours number may be the PCP's home telephone number, an answering service, etc. The after-hours telephone number must be listed in the member's handbook. Changes to the after hours number should be reported to the CSO.
   E. Provide preventive services as defined by the network advisory board.
   F. Offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
   G. Establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members.
   H. Refer members for additional medically necessary care to other health care providers using the system provided by the CSO.
   I. Follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS).
   J. Utilize the following federal standards for appointment availability:
      - Emergency care – immediately upon presentation or notification
      - Urgent care – within 48 hours of presentation or notification
      - Routine sick care – within 3 days of presentation or notification
      - Routine well care – within 45 days of presentation or notification (15 days if pregnant)
   K. Utilize the following federal standards for office visit times:
      - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
      - Scheduled appointment – within 45 minutes
      - Life-threatening emergency –must be managed immediately

Medical Homes Network Primary Care Providers

A Primary Care Physician (PCP) is an individual physician or group medical practice that agrees to serve as the Member's primary physician, contribute to the development and implementation of a care treatment plan, when appropriate, and participate in quality of care initiatives and reviews. The PCP provides and/or arranges for most of the members' healthcare needs. PCPs are required to either provide services or authorize another provider to treat the member.

South Carolina Medicaid providers who are interested in participating in a MHN should call the SCDHHS Division of Care Management at 803-898-4614 to obtain information on becoming part of a MHN. The Medical Homes Program Manager will inform the provider of the available Network options.

SCDHHS enroll s qualified PCPs who are contracted with a Network into the MHN program. The PCP will contract with the CSO/Network. SCDHHS does not contract directly with the PCP.

The following Medicaid provider types may enroll as a Medical Homes Primary Care Provider:

- Family Medicine
- General Practice
- Pediatrician
- Internal Medicine
- OB/GYN
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

The decision to allow other provider types to join a particular network will be at the discretion of the Network. Other provider types wishing to participate in a Medical Homes Network should petition/contact the local Network.

BENEFICIARY ENROLLMENT

Who is Eligible to Enter an MHN?

Enrollment in MHN is voluntary. All Medicaid eligible beneficiaries may enroll in the program except those who:

- Are institutionalized or in a nursing home;
- Have limited Medicaid benefits, such as Family Planning waiver recipients;
- Are enrolled in another Medicaid managed care entity.

Enrollment should be restricted to beneficiaries who reside sufficiently near the delivery site or PCP's practice so that they may reach that site within a reasonable time using available and affordable modes of transportation.

How Is Eligibility Determined

Individuals who meet financial and categorical requirements may qualify for Healthy Connections Choices (Medicaid).

The South Carolina Department of Health and Human Services (SCDHHS) determines eligibility for Medicaid. An individual applying for Medicaid as an SSI recipient must apply at the local Social Security office. Generally, an individual who is approved for SSI will automatically receive Medicaid. Applications for all other coverage groups may be filed in person or by mail. Applications may be filed at out-stationed locations such as the county health departments, federally qualified rural health centers, most hospitals and the county Department of Social Services. Applications may be mailed to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing
Post Office Box 100101
Columbia, South Carolina 29202-3101

Persons who are approved for Healthy Connections Choices (Medicaid) receive a permanent, plastic Healthy Connections Choices (Medicaid) card. They are instructed to take the card with them when they receive a medical service.

Enrollment Process

SCDHHS has instituted an enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). It is currently operated under contract with MAXIMUS Inc. Additional details on SCHCC may be found at www.scchoices.com. Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process who also meet the criteria for Medicaid managed care participation will be informed of their various managed care choices. Before being assigned to a plan by SCHCC, beneficiaries who are eligible for plan assignment are given at least thirty (30) days to choose a plan or decide to remain

in the fee-for-service Medicaid program. Beneficiaries not eligible for plan assignment may proactively enroll in a managed care plan (see Payment Categories chart below for a listing of eligibility types and assignment status).

Since South Carolina operates a voluntary managed car system, current Medicaid recipients may enroll at any time with a managed care option. Also, once a person has joined or been assigned to a managed care plan, they have ninety (90) days in which they may transfer to another plan or to fee-for-service Medicaid without cause. After the 90-day choice period has expired, members must remain in their health plan until their one year anniversary date unless they have a special reason to make a change (see disenrollment section for details).

Enrollment Period

Medicaid MHN members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment once without cause at any time during the 90 days following the date of the member's initial enrollment or re-enrollment with the MHN. After the end of this 90 day period, a member shall remain in the MHN's plan unless the member:

- Submits an electronic, oral or written request to disenroll or change managed care plans for cause which is subsequently approved by SCDHHS,
- The member becomes ineligible for Medicaid, and/or
- The member becomes ineligible for MHN enrollment.

A member may request disenrollment from the MHN as follows:

- For cause, at any time.
- Without cause, at the following times:
    - During the 90 days following the members initial enrollment or re-enrollment with the MHN. This is the Member Choice Period.
    - At least once every 12 months thereafter.

All member initiated disenrollment requests must be made to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker.

A member's request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved.

A member may request disenrollment from the MHN for cause at any time. For cause disenrollment requests must be submitted to SCHCC on the appropriate SCHCC form.

The following are considered cause for disenrollment by the member:

- The member moves out of the MHN's service area;
- The PCP does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
- Other reasons, including but not limited to, poor quality of care, lack of access to services, or lack of access to providers experienced in dealing with the member's health care needs.

Prior to approving the member's disenrollment request, SCDHHS will refer the request to the MHN to explore the member's concerns and attempt to resolve them. The MHN will notify SCDHHS within 10 days of the result of their intervention. The final decision on whether to allow the member's disenrollment rests with SCDHHS, not the MHN. If a decision has not been reached within sixty (60) days, the member's request to disenroll shall be honored. The recipient shall be disenrolled from the first plan effective the last day of the month (depending upon the cut-off cycle) and will be enrolled in the new plan effective the first of the following month.

Annually, SCDHHS will mail a re-enrollment offer to MHN members to determine if they wish to continue to be enrolled with the MHN. Unless the member becomes ineligible for the MHN or provides written notification that they no longer wish to be enrolled in the MHN, the member will remain enrolled with the MHN.

Enrollment is limited to 2,500 Beneficiaries (Medicaid MHN members and existing commercial members) per full-time physician, unless otherwise approved by the SCDHHS.

Disenrollment

Disenrollments may be initiated by (1) the member, (2) SCDHHS or (3) the Contractor. Member-initiated disenrollment is addressed above in the section entitled **Enrollment Period.** The MHN may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. The MHN may contact the member upon receipt of the monthly member listing file. However, follow up must be within the guidelines outlined in this guide.

A Medicaid MHN program member who becomes disenrolled due to loss of Medicaid eligibility but regains Medicaid eligibility within sixty (60) calendar days will be

automatically enrolled in the MHN's plan. Depending on the date eligibility is regained, there may be a gap on the member's MHN coverage. If Medicaid eligibility is regained after 60 calendar days, the reinstatement of Medicaid eligibility will prompt the SCDHHS Enrollment Broker to mail an enrollment packet to the beneficiary. The beneficiary may also initiate the re-enrollment process without an enrollment packet.

The SCDHHS will notify the MHN of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of Medicaid MHN program eligibility;
- Death of a Member;
- Member's intentional submission of fraudulent Information;
- Becomes an inmate of a Public Institution (see Appendix A – Definition of Terms)
- Member moves out of State;
- Member becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Loss of MHN's participation;
- Enrollment in another MCO through third party coverage;
- Enrollment in another Medicaid managed care plan.

The MHN shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MHN Program member whose enrollment should be terminated prior to SCDHHS' knowledge.

The MHN shall have the right to contact MHN members who have been disenrolled when the reason for disenrollment is "ineligible for Medicaid". This means that Medicaid eligibility has been terminated.

The MHN may request to disenroll a Medicaid MHN Program member based upon the following reasons:

- MHN ceases participation in the Medicaid MHN program or in the Medicaid MHN Program member's service area;
- Member dies;
- Member becomes an inmate of a Public Institution;
- Member moves out of State or MHN's service area;
- Member becomes Institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Medicaid MHN Program member's behavior is disruptive, unruly, abusive or uncooperative.
- Member fails to follow the rules of the managed care plan;

The MHN's request for member disenrollment must be made in writing to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker, using the SCDHHS Plan Initiated Disenrollment Form in **MHN Policy and Procedure Guide.** The request must state the detailed reason for disenrollment. SCHCC will log this request and forward it to SCDHHS for review. SCDHHS will determine if the MHN has shown good cause to disenroll the member and SCDHHS will give written notification to the MHN and the member of its decision. The MHN and the member shall have the right to appeal any adverse decision.

The MHN may not request disenrollment because of any adverse change in the member's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.)

The same time frames that apply to enrollment shall be used for changes in enrollment and disenrollment. If a member's request to be disenrolled or change plans is received and processed by SCDHHS by the internal cutoff date for the month, the change will be effective on the last day of the month. If the member's request is received after the internal cutoff date, the effective date of the change will be no later than the last day of the month following the month the disenrollment form is received. A Member's disenrollment is contingent upon their "lock-in" status (see **Enrollment Period** Section).

Guidelines for Involuntary Member Disenrollment	
Reason for Involuntary Disenrollment	**Disenrollment Effective Date**
Loss of Medicaid eligibility	Member will be auto-disenrolled during the next processing cycle.
Death of Member	Leave enrollment through the month of death. Member will be disenrolled at the end of the month of death. Any premiums for months following the month of death will be recouped.
Intentional submission of fraudulent information	Member will be disenrolled at the earliest effective date allowed.
Member becomes inmate* of public institution	Leave enrollment through the month of incarceration. Member will be disenrolled at the end of the month of incarceration. Any premiums for months following the month of incarceration will be recouped.
Member moves out of state	Leave enrollment through the month the member moves out of state. Member will be disenrolled at the end of the month of the move. Any premiums for months following the month of the move will be recouped.
Member in LTC/NH >30 days	Member will be disenrolled at the earliest effective date allowed by system edits.
Loss of MHN's participation	Member will be disenrolled based on MHNs termination date
Member enrolled in another MCO through third party liability	Leave enrollment until the month of private MCO coverage. Member will be disenrolled at the end of the month of new enrollment. Any premiums for months following the month of enrollment in private MCO or other Medicaid managed care plan coverage will be recouped.
Member fails to follow rules of managed care plan.	Member will be disenrolled at the earliest effective date allowed by system edits.
**SCDHHS policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the Medicaid program. These exceptions will be considered on a case by case basis.* **Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.*	

PCAT	PAYMENT CATEGORY	Major Group	MCO participation	MHN participation	PGM-TYPE	Auto	Outreach Only
	Regular Medicaid						
10	MAO (Nursing Home)	Elderly/Disabled			X - not MGC elig	N	N
11	MAO (Extended/Transitional)	Low Income Families	X	X	B - both MCO or MHN	Y	N
12	OCWI (Infants)	Pregnant Women and Infants	X	X	B - both MCO or MHN	N	Y
13	MAO (Fostercare/Adoption)	Low Income Families	X	X	B - both MCO or MHN	N	Y
14	MAO (General Hospital)	Elderly/Disabled			X - not MGC elig	N	N
15	MAO (Waivers - Home & Community)	Elderly/Disabled		X	P - MHN only	N	Y
16	Pass Along Eligibles	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
17	Early Widows/Widowers	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
18	Disabled Widows/Widowers	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
19	Disabled Adult Children	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
20	Pass Along Children	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
31	Title IV-E Foster Care	Low Income Families	X	X	B - both MCO or MHN	N	Y
32	Aged, Blind, Disabled (ABD)	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
33	ABD Nursing Home	Elderly/Disabled			X - not MGC elig	N	N
40	Working Disabled	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
48	Qualifying Individuals (QI)	Elderly/Disabled			X - not MGC elig	N	N
50	Qualified Disabled Working Individual	Elderly/Disabled			X - not MGC elig	N	N
51	Title IV-E Adoption Assistance	Low Income Families	X	X	B - both MCO or MHN	N	Y
52	SLMB	Elderly/Disabled			X - not MGC elig	N	N
54	SSI Nursing Home	Elderly/Disabled			X - not MGC elig	N	N
55	Family Planning Waiver	Low Income Families			X - not MGC elig	N	N
57	Katie Beckett/TEFRA	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
59	Low Income Families	Low Income Families	X	X	B - both MCO or MHN	Y	N

60	Regular Foster Care	Low Income Families	X	X	B - both MCO or MHN	N	Y
71	Breast and Cervical Cancer	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
80	SSI	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
81	SSI With Essential Spouse	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
85	Optional Supplement	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
86	Optional Supplement & SSI	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
87	OCWI Pregnant Women /Infants	Pregnant Women and Infants	X	X	B - both MCO or MHN	Y	N
88	OCWI Partners For Healthy Children	Children	X	X	B - both MCO or MHN	Y	N
90	Qualified Medicare Beneficiary	Elderly/Disabled			X - not MGC elig	N	N
91	Ribicoff Children	Low Income Families	X	X	B - both MCO or MHN	Y	N
E	Emergency Services				X - not MGC elig	N	N
I	Inmate Services				X - not MGC elig	N	N
C	Emergency/Inmate Services				X - not MGC elig	N	N
D	DJJ Inmate Services				X - not MGC elig	N	N
J	DJJ Emergency Inmate Services				X - not MGC elig	N	N
P	Other Inmate Services				X - not MGC elig	N	N
A	Other Emergency Inmate Services				X - not MGC elig	N	N
X	SCHIP Recipient in Paycat 88						
B	Medicaid Recipient in DJJ Grp Home (non-SCHIP)				X - not MGC elig	N	N
G	SCHIP Recipient in DJJ Grp Home				X - not MGC elig	N	N
	SCHIP						
99	Healthy Connections Kids		X		S - SCHIP MCO only	Y	N
	Others						
70	Refuge Entrant	Low Income Families			X - not MGC elig	N	N
92	GAPS (Medicare Part D Plan)	Elderly/Disabled			X - not MGC elig	N	N

RSP Indicator	RSP Code	MHN	MCO	Potential File (Outreach)	New/Review File (Assignment Mailings)	Eligible for Dental Benefits
AUTW Autism Waiver	**8**	YES	**NO**	YES	**NO**	YES
CHPC CLTC Children's Personal Care Aide	**H**	YES	YES	YES	**NO**	YES
CLTC Elderly Disabled Waiver	**A**	YES	**NO**	YES	**NO**	YES
CSWE Community Supports Waiver - Established	**D**	YES	**NO**	YES	**NO**	YES
CSWN Community Supports Waiver - New	**C**	YES	**NO**	YES	**NO**	YES
DMRE DMR Waiver/Established	**M**	YES	**NO**	YES	**NO**	Adults in this RSP are granted the same benefits as any Medicaid recipient under the age of 21.
DMRN DMR Waiver/New	**L**	YES	**NO**	YES	**NO**	Adults in this RSP are granted the same benefits as any Medicaid recipient under the age of 21.
HIVA CLTC HIV AIDS	**F**	YES	**NO**	YES	**NO**	YES
HOAD Healthy Opportunity Account; in deductible period	**7**	**NO**	**NO**	**NO**	**NO**	YES
HOAP Healthy Opportunity Account; no co-pay	**6**	**NO**	**NO**	**NO**	**NO**	YES
HSCE Head & Spinal Cord Waiver Established	**S**	YES	**NO**	YES	**NO**	YES
HSCN Head & Spinal Cord Waiver New	**T**	YES	**NO**	YES	**NO**	YES
ISED Interagency Sys. Of Care for Emotion. Disturbed Children	**I**	YES	YES	YES	**NO**	YES
MCFC Medically Fragile Children's Program	**U**	**NO**	**NO**	**NO**	**NO**	YES
MCHS Hospice	**K**	YES	**NO**	YES	**NO**	YES
MCNF Medically Fragile Non-Foster Care	**W**	**NO**	**NO**	**NO**	**NO**	YES
MCPC Integrated Personal Care Services	**Z**	YES	YES	YES	**NO**	YES
MCSC Pace	**J**	**NO**	**NO**	**NO**	**NO**	YES
NHTR Nursing Home Transition	**4**	**NO**	**NO**	**NO**	**NO**	YES

PRTF Psychiatric Residential Treatment Facility Demonstration Waiver for SED Children	**9**	YES	NO	YES	**NO**	YES
VENT CLTC Ventilator Dependent Waiver	**V**	YES	**NO**	YES	**NO**	YES
WAHS Waiver Healthy Start	**P**	YES	YES	YES	**NO**	YES
WMCC Medically Complex Children's Waiver	**3**	YES	**NO**	YES	**NO**	YES
Non-Pay Cat/RSP Eligiblity						
Dual Eligibles (Medicare/Medicaid)		YES	NO	YES	NO	YES
Aged 65 or over		YES	NO	YES	NO	YES

MEMBER BENEFITS

The following list of services and benefits are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. MHN plans are required to provide Medicaid MHN Program members "medically necessary" care, at the very least, at current limitations for the following services. Unless otherwise specified, service limitations are based on the State Fiscal Year (July 1 - June 30. More detailed information on Medicaid policy for services and benefits may be found in the corresponding Provider Manual. These manuals are available electronically on the SCDHHS website at http://www.scdhhs.gov.

MHN plans may offer expanded services to Medicaid MHN Program members. Additions, deletions or modifications to the expanded services made during the contract year must be submitted to SCDHHS for approval. These expanded services may include medical services which are currently non-covered and/or which are above current Medicaid limitations.

SCDHHS, on a regular basis, may expand, limit, modify or eliminate specific services, procedures and diagnosis codes offered by the SC Medicaid program. These changes may also affect maximum reimbursement rates and service limitations. Generally, these changes are documented and distributed via Medicaid bulletin.

Physician Services

Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics and skilled facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service. There is no limit on ambulatory visits for adult MHN members.

Early & Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child

The EPSDT program provides comprehensive and preventive health services to children through the month of their 21st birthday. The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid recipients and their patents or guardians effectively use these resources.

The MCO will assure that the EPSDT program contains the following benefits:

- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical Exam
- Appropriate Immunizations

- Laboratory Tests
- Lead Toxicity Screening
- Health Education
- Vision Services
- Dental Services
- Hearing Services

The MHN is responsible for assuring that children through the month of their 21st birthday are screened according to the American Academy of Pediatrics (AAP) periodicity schedule http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf).

Communicable Disease Services

An array of communicable disease services are available to help control and prevent diseases such as TB, syphilis, and other sexually transmitted diseases (STD's) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases.

Eligible beneficiaries should be encouraged to receive TB, STD, and HIV/AIDS services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. Eligible beneficiaries have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions to services.

Family Planning Services

An array of family planning services is available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered services include traditional contraceptive drugs and supplies and preventive contraceptive methods. Family planning services are also available through special teen pregnancy prevention programs. Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is "Family Planning."

Eligible beneficiaries should be encouraged to receive family planning services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. However, eligible beneficiaries have the freedom to receive family planning services from any appropriate Medicaid providers without any restrictions.

Care Coordination

Care Coordination is comprised of all activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management. The Care Coordinator is responsible for assuring that members receive all needed and appropriate services through their PCP and appropriate specialty and/or ancillary services providers.

Member Education

As the coordinator of care, the MHN (CSO and PCP) must be actively involved in member education. The CSO will provide the PCP with a monthly listing of all new enrollees.

Each new member must receive an orientation during which the following subjects are addressed:

- The PCP's requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PCP.
- The member's responsibility to bring his/her Medicaid card to each appointment.
- The member's responsibility to contact the PCP for a referral before going to any other doctor.
- The member's responsibility to use emergency care appropriately and contact the PCP before going to the emergency department, unless the member feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits, such as EPSDT screening for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings.

Member Services

The MHN shall maintain an organized, integrated member services entity/department to assist members in understanding the program's policies and procedures. The Member Services entity can provide additional information about the Network's primary care providers, facilitate referrals to participating specialists, and assist in the resolution of service and/or medical delivery concerns or problems. The MHN shall identify and educate members who access the system inappropriately; and, provide additional education as needed.

The MHN shall provide a written description of its member services function to give to its members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS.

The written description must include information on the following:

- The appropriate utilization of services
- How to access services;
- How to select a primary care physician;
- Access to out-of-plan care;
- Emergency care (in or out-of-area);
- The process for prior authorization of services;
- Toll free telephone number for member services;
- Written explanation containing a Statement of Understanding authorizing the provider to release medical information to the federal and state governments or their duly appointed agents;
- Member's rights.

MEDICAL HOMES NETWORK AND PROVIDER REQUIREMENTS

The Scope of Work the CSO is expected to perform consists of the components listed below. These components must also be described in detail as part of the **Application Packet** process:

Organization

- Describe the organizational structure including organization chart, major departments, staffing and individual contact information/responsible parties.
- Describe the qualification, credentials and experience of management staff and medical professionals. For those positions not filled, submit descriptions for each position/classification.
- Describe the administrative, financial and information technology resources which support the day-to-day operations of the MHN.
- Demonstrate financial soundness. Provide assurances that the State of South Carolina, SCDHHS or Medicaid beneficiaries will not be liable for the MHN's debt if the Network becomes insolvent. The MHN must provide evidence of a reserve account with a federally guaranteed financial institution.
- Demonstrate or describe the MHN's ability to comply with current HIPAA regulations.
- Describe or demonstrate the MHN's ability to meet the fiscal requirements are found in the MHN contract.
- Describe the MHN's plan/ability to begin full operation within 30 days of receiving a contract from DHHS.

Physician Recruitment and Support

- Describe the recruitment plan and process for obtaining a comprehensive physician network. This description should include strategies for obtaining services in underserved areas, working cooperatively with existing hospital-owned networks and other challenges specific to South Carolina identified.
- Provide the detailed plan to coordinate with, and educate health care providers and sustain participation and coordination with these providers. Previous experience should be provided including submitting documentation of education provided to the providers over the past 5 years and submitting evidence of provider retention over the past 5 years (Provider retention must be at least 80%).
- Provide descriptions of processes, including sample reports, of network and physician management in the areas of provider satisfaction, member satisfaction, quality data, quality improvement and cost effectiveness.
- Demonstrate the CSO/MHN's ability or describe its capability to assure ongoing monitoring and evaluation of provider service utilization and progress on program outcomes. Submit sample reports.
- Demonstrate the CSO/MHN's ability or describe its capability to manage and analyze member and provider demographic, utilization, and cost data. Submit sample reports.

Medical Home Network Processes and Products

- Demonstrate and provide specific processes and reports that describe the CSO/MHN's utilization management abilities to include referral management, drug utilization review, and practice guidelines.
- Demonstrate the CSO/MHN's ability or describe its capability to identify and address quality of care issues (e.g., identify gaps between recommended prevention and treatment and actual care provided to members).
- Demonstrate the CSO/MHN's ability or describe its capability to engage the target populations (PCPs and Beneficiaries/Members) resulting in provider and member satisfaction and to facilitate increased coordinated access to care.
- Demonstrate the CSO/MHN's ability or describe its capability to apply nationally recognized, evidence-based clinical guidelines in the application of services.
- Demonstrate the CSO/MHN's ability or describe its capability to educate members and/or their caregivers regarding child development, childhood diseases, and any particular health care condition and the needs brought about by health problems, with the goal of increasing member and/or caregiver understanding and to enhance their effectiveness in self-care. Submit examples of education programs, materials and activities developed for or provided to members.
- Demonstrate the CSO/MHN's ability or describe its capability to manage various health and any co-morbid conditions.
- Demonstrate the CSO/MHN's ability or describe its capability to assure ongoing monitoring and evaluation of member health status. Submit detailed descriptions of activities implemented to address health status issues and the resulting effects in acute care costs.

1. Demonstrate the CSO/MHN's information technology proficiency to include:
   - Enrollment tracking,
   - Re-determination tracking,
   - Data support for referral management and care management services,
   - Ownership of or a contractual relationship with a data warehouse or central database with the ability to provide monthly, yearly, and ADHOC reports to affected/interested parties, including individual physicians and SCDHHS.

2. Describe the CSO/MHN's care management protocols to include:
   - Staffing criteria,
   - Procedures for identifying patients in need of care management,
   - Procedures for working with families and other community supports/providers,
   - Procedures to engage members in care management,
   - Care manager access protocols (Please describe how a member accesses the care manager; i.e., assignment, request, chronic condition, missed appointment, etc.),
   - Care management protocols for specific diseases, and
   - Patient education methods and capacities.

NOTE: The CSO may operate its 24-hour Help Line outside of South Carolina. However, in anticipation of care coordination services that must be delivered face-to-face, the CSO will be expected to employ or contract with local Care Coordinators.

Medical Home Network Required Protocols

Develop and submit the following protocols:

A. A protocol to ensure regular evening and weekend office hours to accommodate the needs of the members. This must be submitted within six (6) months of the Network beginning operations.
B. A protocol to provide medical homes for Medicaid patients that do not have a medical home and/or use the Emergency Room as their PCP.
C. A protocol to educate Medicaid beneficiaries on appropriate use of the ER and other medical services and to divert members from the emergency room to urgent care or primary care when appropriate.
D. A protocol to control, monitor and follow-up on care provided by other medical service providers for diagnosis and treatment.
E. A protocol for furnishing providers and members with evidence-based information and resources to support optimal health management.
F. A protocol that emphasizes and defines prevention and self-care
G. A data management, reporting and feedback process with Network members to track exceptions and performance, to improve health outcomes, document cost effectiveness, including monthly patient profile reports. SCDHHS will provide data to the Network and the providers, which detail the claims activities on all enrolled members.
H. A protocol on maintaining Medicaid eligibility, to include providing assistance to members in completing the eligibility renewal process to reduce the percent of members whose eligibility is interrupted due to failure to respond properly during the re-determination process.
I. Protocol to education new and potential members on the enrollment process.
J. A protocol to ensure the cultural competency of the Network.
K. A protocol for involving the participating physicians in the oversight and direction of initiatives for the network to include:
    - ✓ Establishing best practices
    - ✓ Monitoring overall quality of care within the network
    - ✓ Monitoring overall network costs to Medicaid
    - ✓ Utilization of data management to improve healthcare for the state

Primary Care Providers who enter into a contract with a Medical Homes Network will be expected to meet certain conditions. The CSO will be responsible for ensuring that providers meet these conditions:

1. The practice must be willing to accept new Medicaid patients not to exceed the practice's established capacity.
2. The practice must provide primary care and patient care coordination services to each member.
3. The practice must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week.
4. The practice must provide preventive services as defined by the network.

5. The practice must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
6. MHN PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members. The practice must assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers.
7. The practice must follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS). The practice shall utilize the following standards for Appointment Availability:
    - Emergency care – immediately upon presentation or notification;
    - Urgent care – within 48 hours of presentation or notification;
    - Routine sick care – within 3 days of presentation or notification;
    - Routine well care – within 45 days of presentation or notification (15 days if pregnant).
8. The practice shall utilize the following standards for office visit times:
    - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above;
    - Scheduled appointment – within 45 minutes;
    - Life-threatening emergency –must be managed immediately.

Failure to meet these requirements could result in the imposition of sanctions on the PCP, the CSO, and/or the Network as a whole. Providers' rights are detailed in the Bill of Rights section.

24-Hour Coverage Requirement

MHN requires PCPs to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

PCPs must provide members with an after-hours telephone number. The after-hours telephone number must connect the member to:

- An answering service that promptly contacts the PCP or the PCP-authorized medical practitioner; or
- A recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner; or
- A system that automatically transfers the call to a telephone line that is answered by a person who will promptly contact the PCP or the PCP-authorized medical practitioner; or
- A call center system; or

- The PCP's home telephone number, if he/she so chooses.

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours or answered with a recorded message instructing members to call back during office hours or to go to the emergency department for care is not acceptable. Additionally, it is not acceptable to refer members to a telephone number if there is no system in place, as outlined above, to respond to calls. PCPs are encouraged to refer patients with after-hours urgent medical problems to an urgent care center rather than the emergency room, provided there is one accessible to the members.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 48 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 45 days of presentation or notification (15 days if pregnant)

Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
- Scheduled appointment – within 45 minutes
- Life-threatening emergency – must be managed immediately

Hospital Admitting Privileges Requirement

MHN PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members. This requirement must be met prior to the PCP providing medical services to members. A voluntary written agreement between the MHN PCP and a physician or group who agrees to admit MHN members for the PCP fulfills this requirement for participation. By signing such an agreement, the

physician/group agrees to accept responsibility for admitting and coordinating medical care for the member throughout the member's inpatient stay. This agreement must be completed by both parties. The CSO must keep the original of this document on file. A sample admission agreement can be found in the Forms section.
The following arrangement is acceptable:

- A physician, a group practice, a hospital group, a physician call group (not necessarily a MHN provider) that is enrolled with the South Carolina Medicaid program, and has
- Admitting privileges or formal arrangements at a hospital that is within 30 miles or 45 minutes drive time from the PCP's office. If there is no hospital which meets this geographic criteria, the closest hospital to the MHN PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases where it is determined the benefits of a PCP's participation outweighs the PCP's inability to comply with the admitting privileges requirement.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

MHN PCPs are required to provide EPSDT screening to Medicaid-eligible children under the age of 21. The EPSDT standards are:

1. To provide **EARLY** health assessments of the child who is Medicaid eligible so that potential diseases can be prevented.
2. To **PERIODICALLY** assess the child's health for normal growth and development.
3. To **SCREEN** the child through simple tests and procedures for conditions needing closer medical attention.
4. To **DIAGNOSE** the nature and cause of conditions requiring attention, by synthesizing finds of the health history and physical examination.
5. To **TREAT** abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

The components of the required screening services are listed in the SCDHHS Physicians provider manual.

The most current Recommended Childhood Immunization Schedule and EPSDT Screening Age Guidelines are available through the Centers for Disease Control and Prevention (www.cdc.gov).

Adult Preventive Health Assessments

MHN PCPs are expected to provide all of the components of an initial preventive health assessment and periodic assessments to adult members age 21 and over. Adult physical examination guidelines are found in the SCDHHS Physicians provider manual.

Women, Infants, and Children (WIC) Program Referrals

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. MHN PCPs are required to refer potentially eligible members to the WIC program. Sample copies of the WIC Referral Form and, the Medical Record Release form are available in the Forms section.

For more information, contact the local WIC agency at the county health department.

Transfer of Medical Records

MHN PCPs must transfer the member's medical record to the receiving provider upon the change of the PCP and as authorized by the member within 30 days of the date of the request.

Medical Records Guidelines

Medical records should reflect the quality of care received by the patient/member. In order to promote quality and continuity of care, the following guidelines are given as the standards for medical record keeping. These guidelines are intended for MHN PCPs.

It is expected that the medical record should include the following for the benefit of the patient and the physician:

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (ages 12 and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.

11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with MHN.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic tests, therapies, and other prescribed regimens, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services
15. In accordance with section 5.1.11 of the MHN contract and state law, Medicaid MHN members and their representatives must be given access to and can request copies of member medical records to the extent and in the manner provided for by S.C. Code Ann. §44-115-10 et seq., (Supp. 2000, as amended), subject to reasonable charges.

MEDICAL HOMES NETWORK REFERRALS AND AUTHORIZATIONS

Coordination of care is an essential component of the MHN. PCPs are contractually required to either provide medically necessary services or authorize a referral to another provider to evaluate and/or treat the member. If a member has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, should arrange for authorization on any existing referral (s). **Referral authorization is the responsibility of the PCP/CSO, not SCDHHS**. The Network, at its discretion, may centralize the referral authorization process for the convenience of the member practices. The Network is encouraged to design a referral authorization protocol that will be used by all member practices. In some cases, the PCP may choose to authorize a referral retroactively. Some referrals do not require authorization. (*Refer to the list of exempt services* in this section) All referral authorizations and consultations, including referrals authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include:

- The number of visits being authorized
- The extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number may be used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to evaluate and/or treat a member and then needs to refer the member to a second specialist for the same diagnosis, the member's PCP must be contacted for referral authorization.

Referral authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require referral authorization.** The hospital should contact the PCP for authorization within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital **also** require PCP authorization.

In addition to **MHN** authorization, prior approval (PA) may be required by SCDHHS to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining referral authorization does not guarantee payment or ensure beneficiary eligibility on the date of service.

Claims submitted for reimbursement must include the PCP's referral authorization number.

Referrals for the following services must be authorized by the PCP:

1. Inpatient hospital[1] services except newborn DRGs, Residential Treatment Facilities and Institutions for Mental Disease;
3. Outpatient hospital services except lab and x-ray[2];
2. All other physician services except family planning services and services performed by an obstetrician and/or gynecologist; Podiatry and Chiropractic;
3. All services provided by Nurse Practitioners and Nurse Midwives except family planning services;
4. Services provided by DHEC Clinics except family planning and communicable diseases related services;
5. Services provided by Ambulatory Surgical Centers (except family planning services);
6. Services provided by FQHCs and RHCs except family planning services (unless the FQHC/RHC is the member's MHN PCP);
7. Home Health; and,
8. Durable Medical Equipment.

[1]FQHCs/RHCs that provide inpatient hospital services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

[2]FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

Referrals for a Second Opinion

MHN PCPs are required to refer a member for a second opinion, at the request of the member, when surgery is recommended.

Referral Documentation

All referrals must be documented in the member's medical record. The CSO and the PCPs should review the monthly referral data to ensure that services rendered to their members were authorized, have been documented and recorded accurately in the member's medical record. It is the PCP's responsibility to review the referral data validity, accuracy and report inappropriate/unauthorized referrals to the CSO. The CSO is responsible for investigating inappropriate/unauthorized referrals and notifying SCDHHS should Medicaid fraud or abuse be suspected.

Exempt Services

Members may obtain the following services from Medicaid providers without first obtaining referral authorization from their PCPs:

- Ambulance
- Dentistry, Pedodontics, Oral Surgery (Dental only)
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services billed by the Hospital or EMTALA services billed by a hospital-based Urgent Care Clinic
- Family Planning Services
- Home and Community Based Waivers
- Independent Lab and X-ray[1]
- Medical Transportation
- Nursing Home
- Obstetrics and Gynecology
- Optician
- Optometry
- Pharmacy
- Medicaid services provided by state agencies, including: Department of Mental Health, Continuum of Care, Department of Alcohol and Other Drug Abuse Services, Department of Disabilities and Special Needs, Department of Juvenile Justice, Department of Social Services.
- Speech and Hearing Clinic services
- Developmental Evaluation Center services
- BabyNet services
- Children's Rehabilitative services
- Sickle Cell Anemia services
- Early Intervention services

[1] FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number), must enter a preauthorization number on the claim form or the claim will reject.

Some services still require a prescription or doctor's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements or contact the SCDHHS Program Manager.

Some services may be sponsored by a state agency and require a referral from that agency's case manager. The state agency case manager should coordinate with the PCP and the Network Care Coordinator to insure continuity of care. These services include, but are not limited to, the following:

- Audiology
- High/Moderate Management Group Home services
- Occupational Therapy
- Physical Therapy
- Psychology
- Speech Therapy
- Therapeutic Foster Care

MARKETING

The MHN shall be responsible for developing and implementing a written marketing/advertising plan designed to provide the Medicaid beneficiary with information about the MHN's medical home program. All marketing/advertising and member education materials must contain the 1-877-552-4642 telephone number of the statewide Healthy Connections Help Line and the plan's toll free number. The marketing/advertising plan and all related accompanying materials are governed by 42CFR § 438.104 and the following definitions and policies. Should an MHN require additional guidance or interpretation, it should consult with the SCDHHS.

Definitions

Beneficiary – A person who is determined to be eligible for Medicaid services.

Member - A Medicaid beneficiary who is enrolled with a Medicaid managed care plan.

Marketing/advertising means any communication, from an MHN to a Medicaid beneficiary who is not enrolled in that entity, which can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MHN's Medicaid product or either to not enroll in, or to disenroll from, another Medicaid product.

Marketing materials/media means materials that (1) Are produced in any medium, by or on behalf of an MHN; and (2) Can reasonably be interpreted as intended to market to beneficiaries. Marketing/advertising and education materials/media include, but are not limited to the following:

Brochures
Fact sheets
Posters
Videos
Billboards
Banners
Signs
Commercials (radio and television ads/scripts)
Print ads (newspapers, magazines)
Event signage
Vehicle coverings (buses, vans, etc)
Internet sites (corporate and advertising)
Other advertising media as determined by SCDHHS

Member education is educational activities and materials directed at MHNs members that increases the awareness and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis. Member education also includes information and materials that inform the member on the MHNs policies, procedures, requirements and practices.

Marketing activities include, but are not limited to, distribution of marketing and advertising materials; health plan promotion, including attendance of community, business and other events; and, any other means of calling public attention to the Medicaid managed care plan or company.

Value Added Items and Services (VAIS) are defined as items and services provided to a member that are not included in the core benefits and are not funded by Medicaid dollars. SCDHHS only allows "health care related" VAIS. Health care related VAIS are items or services that are intended to maintain or improve the health status of members

General Marketing/Advertising and Member Education Policies

All SCDHHS marketing/advertising and member education policies and procedures stated within this Guide apply to staff, agents, officers, subcontractors, volunteers and anyone acting for or on behalf of the MHN.

Violation of any of the listed policies shall subject the MHN to sanctions, including suspension, fine and termination, as described in Section 13 of the MHN contract and as determined by the SCDHHS. The MHN may appeal these actions in writing to SCDHHS.

The MHN's marketing/advertising plan shall guide and control the actions of its marketing staff. In developing and implementing its plan and materials, the MHN shall abide by the following policies:

Permitted Activities

- The MHN is allowed to offer nominal gifts, with a fair market value of no more than $10.00; with such gifts being offered regardless of the beneficiary's intent to enroll in a plan. Cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards **are not permitted** to be given to beneficiaries or general public. Cash gifts, including gift cards, **are permitted** to be given to MHN members as incentives or rewards for healthy behaviors. These are known as health care related "value added items and services (VAIS)."

- The marketing representative is responsible for providing the beneficiary with information on participating PCPs and assisting in determining if his/her current physician is a member of the MHN's network.

- Any claims stating that the MHN is recommended or endorsed by any public or private agency or organization, or by any individual must be prior approved by SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MHN.

- The MHN is allowed to directly and/or indirectly conduct marketing/advertising activities in a doctor's office, clinic, pharmacy, hospital or any other place where health care is delivered, with the written consent of the provider. This also includes government facilities, such as local offices of the South Carolina Department of Health and Human Services, the Department of Social Services, the Department of Health and Environmental Control, HeadStart and public schools. The use of government facilities is only allowed with the written permission of the government entity involved. Any stipulations made by the provider or government entity must be followed (allowable dates, times, locations, etc).

- All marketing/advertising activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

- The MHN may provide approved marketing/advertising and educational materials for display and distribution by providers. This includes printed material and audio/video presentations.

- Upon request by a Medicaid beneficiary, marketing representatives may provide him/her with information (excluding an enrollment form) about the MHN to give to other interested Medicaid beneficiaries (i.e. business card, marketing brochure).

Activities Which Are Not Permitted

- The MHN is prohibited from distributing enrollment forms or aiding a Medicaid beneficiary in filling out or transmitting an enrollment form in any way.

- When conducting marketing/advertising activities, the MHN shall not use their personal or provider-owned communication devices (i.e. telephone or cell phone, fax machine, computer) to assist a person in enrolling in a health plan.

- The MHN shall not make any claims or imply in any way that a Medicaid beneficiary will lose his/her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with a managed care plan.

- The MHN cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to Medicaid beneficiaries to induce plan enrollment.

- The MHN (and any subcontractors or representatives of the MHN) shall not engage in marketing/advertising practices or distribute any marketing/advertising materials that misrepresent, confuse or defraud Medicaid beneficiaries, providers or the public. The MHN shall not misrepresent or provide fraudulent misleading information about the Medicaid program, SCDHHS and/or its policies.

- The MHN cannot discriminate on the basis of a beneficiary's or member's health status, prior health service use or need for present or future health care services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll a member except as permitted by Title XIX.

- The MHN's marketing representatives may not solicit or accept names of Medicaid beneficiaries from Medicaid beneficiaries or MCO/MHN members for the purpose of offering information regarding its plan.

- The MHN may only market in the beneficiary's residence if they obtain a signed statement from the Medicaid beneficiary; giving permission for the MHN's representative to conduct a home visit for the sole purpose of marketing activities.

- The MHN is prohibited from comparing their organization/plan to another organization/plan by name.

Medicaid Beneficiary and MHN Member Contact

- The MHN is not allowed to directly or indirectly, conduct door-to-door, telephonic, or other "cold call" marketing/advertising activities. This includes initiating contact with a member of the public or beneficiary at a marketing event.

- The MHN is not allowed to initiate direct contact (defined as a face to face interaction where communication takes place) with Medicaid beneficiaries for purposes of soliciting enrollment in their plan.

- The MHN may not market directly to Medicaid applicants/beneficiaries in person or through direct mail advertising or telemarketing.

- The MHN may contact members who are listed on their monthly member listing to assist with Medicaid re-certification/eligibility.

- The MHN may conduct an initial follow up with all disenrollees listed on their monthly member listing. However, these activities must be in accordance with marketing requirements, including no direct or indirect "cold call" marketing. The MHN cannot make repeated follow up calls unless specifically requested by the Medicaid beneficiary.

Beneficiary Marketing and Member Education Materials/Media

Marketing may include providing informational materials to enhance the ability of Medicaid beneficiary to make an informed choice of Medicaid managed care options. Such material may be in different formats (brochures, pamphlets, books, videos, and interactive electronic media).

The SCDHHS and/or its designee will only be responsible for distributing general marketing/advertising material developed by the MHN for inclusion in the SCDHHS enrollment package to be distributed to Medicaid beneficiaries. The SCDHHS at its sole discretion will determine which materials will be included.

The MHN shall be responsible for developing and distributing its own beneficiary marketing/advertising and member education materials. The sole exception to this is the member handbook, which shall be developed by SCDHHS. The MHN shall ensure that all Medicaid managed care marketing/advertising and education materials, brochures and presentations clearly present the core benefits and approved expanded benefits, as well as any limitations. The MHN shall also include a written statement to inform beneficiaries and members that enrollment is voluntary.

SCDHHS has established the following requirements for the MHN's Medicaid managed care marketing/advertising and education materials:

- MHNs can, **with SCDHHS written prior approval**, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by MHN), advertising in newspapers, magazines, church bulletins, billboards and buses.

- All marketing/advertising materials/media must include the 1-877-552-4642 telephone number of the statewide Healthy Connections Help Line and the plan's toll free number. Promotional materials (items designed as "give-aways") are excluded from this requirement. Medical education materials for members and third party education publications, such as CDC guidelines, dietary information, disease education, etc., are also exempt.

- All marketing/advertising materials/media, including flyers, brochures, commercials, billboards, websites must include a statement that enrollment is voluntary. Exceptions to this requirement will be considered on a case-by-case basis.

- MHNs can **passively** distribute approved marketing/advertising and educational materials, with written authorization from the entity responsible for the distribution site, to Medicaid beneficiaries and members. Passive distribution is defined as the display of materials with no marketing or education staff present.

- MHNs may mail SCDHHS approved marketing/advertising and educational materials within its approved service areas. Mass mailings directed to only Medicaid beneficiaries are prohibited.

- MHNs' network providers can correspond with beneficiaries concerning their participation status in the Medicaid Program and the MHN. These letters may not contain MHNs' marketing/advertising/education materials or SCDHHS enrollment forms. Letters must be developed, produced, mailed and/or distributed directly by the network provider's office at their expense. This function cannot be delegated by

the provider, to the MHN or an agent of the MHN.

- The MHN shall ensure all materials are accurate, are not misleading or confusing, and do not make material misrepresentations.

- All materials shall be submitted to be reviewed and approved for readability, content, reading level and clarity by SCDHHS or its designee, prior to use or distribution.

- The MHN shall ensure that all written material will be written at a grade level no higher than the fourth (4) grade or as determined appropriate by SCDHHS.

- The MHN shall ensure that appropriate foreign language versions of all marketing/advertising and education materials are developed and available to Medicaid beneficiaries and MHN members. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than ten (10) percent. If counties are later identified, SCDHHS will notify the MHN. These materials must be approved, in writing, by SCDHHS. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request. All material must be separated from the English version.

- When the MHN identifies beneficiaries who have visual and/or hearing impairments, an interpreter must be made available.

- The MHN's written material shall include its current network provider list, which includes names, area of specialty, address, and telephone number(s) of all participating providers, groups and facilities. It shall also include a map or description of the MHN's service area.

- The MHN's written material must include a definition of the terms "emergency medical care" and "urgent medical care" and the procedures on how to obtain such care within and outside of the MHN's service area. SCDHHS shall have responsibility for including this information in the member handbook.

- The MHN must provide a description of its family planning services and services for communicable diseases such as TB, STD, and HIV/AIDS. Included must be a statement of the member's right to obtain family planning services from the plan or from any approved Medicaid enrolled provider. Also included must be a statement of the member’s right to obtain TB, STD, HIV/AIDS services from any state public health agency. SCDHHS shall have responsibility for including this information in the member handbook.

- Summary documents and brochures must include a statement that the document may contain only a brief summary of the plan and that detailed information can be found in other documents, e.g. evidence of coverage, or obtained by contacting the plan.

Marketing Events and Activities

MHNs can conduct, sponsor and participate in marketing/advertising activities only with prior written notice to SCDHHS in a format defined by SCDHHS. Written approval by SCDHHS is NOT necessary. Notice of the date, time and location of each activity/event must be received by SCDHHS three (3) business days prior to the event. A business day is the time period between 8:30am and 5:00pm Eastern time. South Carolina state holidays are excluded from being counted as a business day. (For example, if a marketing event is on Friday the 15th of the month, the notification to SCDHHS must be received by 5:00pm on Monday, the 11th. Using this same example, if Wednesday the 13th is a holiday, the notification must be received by Friday the 8th). Any exceptions to this policy will be considered on a case-by-case basis.

When conducting marketing activities, the MHN may not initiate contact with members of the public or beneficiaries. They may respond to contact initiated by the member of the public or beneficiary. For example, if a marketing representative is operating a booth at a health fair – the representative may give out information or materials, if requested. The representative may not approach a person and give out information or material (including promotional items).

SCDHHS reserves the right to attend all marketing activities/events. The MHN must also secure the written permission of the business or event sponsor to conduct marketing/advertising activities (this satisfies the "written prior approval" requirement of the MHN Contract) and make this document available to SCDHHS, if requested (Fax copies are acceptable).

MHNs may conduct marketing/advertising activities at events and locations including, but not limited to health fairs, health screenings, schools, churches, housing authority meetings, private businesses (excluding providers referenced in this Section) and other community events. The MHN may also be a participating or primary sponsor of a community event. The MHN may not present at employee benefit meetings.

Focus Groups

MHNs may conduct focus group research with their members in order to determine what their member's expectations of the MHN for improving services and benefits to its members, with prior approval from SCDHHS. The request must be received by SCDHHS by noon (12 PM EST) at least twenty (20) business days prior to the first date the focus group will meet. In its request for approval, the MHN must include the following information:

- Identity of the entity conducting the focus group event(s) – MHN staff or name of the contractor the MHN is using.)
- Date, time, contact information and location of each event
- Selection criteria for participation
- Agenda/list of questions being asked to participants

- Participant compensation, separated into monetary amount and other expenses (transportation, refreshments). For instance, If the participant total compensation is $80, the separate monetary amount might be $50 and the other expenses might be $20 transportation voucher and $10 for a meal.

The MHN may not offer gift cards, drawing, prizes or any other type of rewards for members or sponsor attending these meetings. SCDHHS reserves the right to obtain additional information during the review and approval process and to attend focus group meetings.

Member Services

The MHN shall maintain an organized, integrated member services function to assist MHN members in understanding the MCO's policies and procedures. The function of the member services unit is to provide additional information about the MHN's providers, facilitate referrals to providers and assist in the resolution of service and/or medical delivery concerns or problems. The MHN shall identify and educate its members who access the system inappropriately and provide additional education, as needed. The MHN shall provide a written description of its member services functions and handbook to its members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS.

Enrollment

All enrollment activities are to be exclusively conducted by the enrollment broker. This includes distribution of forms, assistance to Medicaid beneficiaries and transmittal of enrollment information to the enrollment broker and SCDHHS.

No distribution of enrollment forms is allowed by a MHN or employee/agent of a MCO. Distribution is defined as making the enrollment form available directly or indirectly through the MHN or representative of the MHN.

Enrollment Incentives

No offers of material or financial gain, other than core benefits expressed in the MHN contract, may be made to any Medicaid beneficiary as incentive to enroll or remain enrolled with the MHN. This includes, but is not limited to, cash, vouchers, gift certificates, insurance policies or other incentive. The MHN can only use, in marketing materials and activities, any benefit or service that is **clearly specified** under the terms of the contract, and available to MHN members for the full contract period which has been approved by SCDHHS. Optional expanded benefits that have been approved by SCDHHS may be used in marketing materials and activities. These benefits include, but are not limited to: reduced or no copayments, additional services and visits over Medicaid limitations or membership in clubs and activities.

QUALITY ASSESSMENT REQUIREMENTS

All MHNs that contract with SCDHHS to provide Medicaid MHN Program Services must have a system of Quality Assessment QA) and Case Management program that meets the following standards:

1. Have a quality assessment system that:

   a) Is consistent with applicable federal regulations;
   b) Provides for review by appropriate health professionals of the process followed in providing health services;
   c) Provides for systematic data collection of performance and patient results;
   d) Provides for interpretation of this data to the practitioners; and
   e) Provides for making needed changes.

2. Maintain and operate a QA program which includes at least the following elements:

   a) Quality Assessment Program Description – a description of the QA program which outlines the MHN's mechanisms to monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The QA efforts should be health outcome oriented and rely upon data generated by the MHN as well as that developed by outside sources. The description must be organized and written so that staff members and practitioners can understand the program's goals, objectives and structure and should incorporate information from customer service, appeals and grievances, medical management, credentialing and provider relations. This description shall be submitted to SCDHHS annually.

   b) QA Staff – The QA plan shall name a quality director, manager or coordinator responsible for the operation of the QA program. Such person shall be a health care professional (i.e. registered nurse, physician, CPHQ), who has the necessary knowledge and skills to design, implement, and maintain ongoing health care quality, patient safety, utilization, and clinical risk management strategies, systems, processes, and associated activities. This person shall spend an adequate percentage of his/her time dedicated to QA activities to ensure the effectiveness of the QA program and be accountable for QA in all MHN providers and subcontractors. In addition, the medical director must have substantial regular involvement in QA activities.

   c) Annual Quality Assessment Work Plan – the work plan should include but not limited to the planned activities, objectives, timeframe or milestones for each activity and the responsible staff member. This document should be submitted to SCDHHS annually and updated frequently to reflect the progress on all activities.

d) Program Integrity Plan (SCDHHS Section 11.1)

e) QA Committee - The MHN's QA program shall be directed by a QA committee which has substantial involvement of the medical director and includes membership from:

- ♦ A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)
- ♦ Participating network providers in a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). The QA committee shall include OB/GYN and pediatric representation; and
- ♦ MHN management, Advisory Boards or Board of Directors.

f) The QA Committee shall be located within the MHN such that it is responsible for all aspects of the QA program.

g) The QA Committee shall meet at least quarterly, produce dated and signed written documentation of all meetings and committee activities and submit such documentation to appropriate entities within the MHN and SCDHHS.

h) The QA activities of MHN providers and subcontractors, shall be integrated into the overall MHN/QA program. The MHN QA Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of and corrective actions necessary in provider/subcontractor QA efforts. QA activities and results shall be reported in writing at least quarterly to the MHN, SCDHHS and its authorized agents.

i) The MHN shall have a written procedure which addresses the MHN's approach to measurement, analysis, and interventions for QA activity findings. This procedure should include monitoring activities following intervention implementation. The measurement, analysis and interventions shall be documented in writing and submitted to appropriate entities with the MHN (i.e. QA Committee) and SCDHHS.

j) The MHN shall make use of the SCDHHS utilization data which is supplied monthly.

k) Quality Assessment and Performance Improvement Program (QAPI): The MHN shall have an ongoing quality assessment and performance improvement program for the services it furnishes to members. At a minimum, the MHN shall:

- ➢ Conduct performance improvement projects as described in this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement. This

improvement should be sustained over time, and have favorable effect on both health outcomes and enrollee satisfaction.

- Submit performance measurement data as described below.
- Have in effect mechanisms to detect both under-utilization and over-utilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

    - Performance Measurements:

Annually the Contractor shall:

- Measure and report to SCDHHS its performance, using standard measures required by SCDHHS.
- Submit to SCDHHS data specified by SCDHHS, that enables SCDHHS to measure the performance; or
- Perform a combination of the activities described in the items listed above.

    - Performance Improvement Projects (PIP): The Contractor shall have an ongoing program of performance improvement projects (a minimum of two projects) that focus on clinical and non-clinical areas, and that involve the following:

        - Measurements of performance using objective quality indicators.
        - Implementation of system interventions to achieve improvement in quality.
        - Evaluation of the effectiveness of the interventions.
        - Planning and initiation of activities for increasing or sustaining improvement.

        - The Contractor shall report the status and results of each project to SCDHHS, as requested.
        - Each performance improvement project must be completed in a reasonable and agreed-upon time period.

l) Annual Written Evaluation of the QA program – An annual evaluation of the overall effectiveness of the QA and Performance Improvement Program.

3. Submit information resulting from quality of care studies which includes care and services to be monitored in certain priority areas, as designated by SCDHHS. Such information shall include sufficient detail on purpose, scope, methods, findings, and outcomes of such studies to enable the SCDHHS to understand the impact of the studies on the MHNs health care delivery system.

- At a minimum, required quality of care studies will include measures for prenatal care, newborn care, childhood immunizations, asthma, ER utilization and EPSDT examinations. Quality Measure Reports must be submitted to SCDHHS on a quarterly basis.

4. Assist the SCDHHS in its quality assurance activities.

    a) The MHN will assist, SCDHHS and SCDHHS's External Quality Review Organization (EQRO) as needed in the identification of provider and beneficiary data required to carry out on-site medical chart reviews.

    b) The MHN will arrange orientation meetings for physician office staff concerning on-site medical chart reviews.

    c) The MHN will assist SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.

    d) The MHN will facilitate training provided by SCDHHS to its providers.

    e) The MHN will allow duly authorized agents or representatives of the State or Federal government access to MHN's premises or MHN subcontractor premises to inspect, audit, monitor or otherwise evaluate the performance of the MHNs or subcontractors contractual activities.

5. Assure that all persons, whether they are employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations and are eligible to participate in the Medicaid/Medicare program (as required in the MHN Contract).

    a) The MHN shall have policies and procedures for approval of new providers and termination or suspension of a provider.

    b) The MHN shall have a mechanism for reporting quality deficiencies which result in suspension or termination of a provider.

6. Have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:

    a) Management and integration of health care through primary care providers.
    b) A referral system for medically necessary, specialty, secondary and tertiary care.
    c) Assurance of the provision of emergency care, including an education process to help assure that members know where and how to obtain medically necessary care in emergency situations.

7. The MHN shall have a system for maintaining medical records for all Medicaid members in the plan to ensure the medical record:

    a. Is accurate, legible and safeguarded against loss, destruction or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit. The MHN shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each Medicaid member. Such records shall be readily available to SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled member. Procedures shall also exist to facilitate the prompt transfer of patient care records to other in - or out-of-plan providers.
    b. Is readily available for MHN-wide QAI and CM activities and provides adequate medical and clinical data required for QA/CM.

    c. Has adequate information and record transfer procedures to provide continuity of care, when members are treated by more than one provider.

    d. Contain, at a minimum, the following items:

        - ✓ Patient name, Medicaid identification number, age, sex and places of residence and employment and responsible party (parent/guardian).
        - ✓ Services provided through the MHN, date of service, service site and name of service provider.
        - ✓ Medical history, diagnoses, prescribed treatment and/or therapy and drug(s) administered or dispensed. The medical record shall commence on the date of the first patient examination made through or by the MHN.
        - ✓ Referrals and results of specialist referrals.
        - ✓ Documentation of emergency and/or after-hours encounters and follow- up.
        - ✓ Signed and dated consent forms.
        - ✓ For pediatric records **(ages 12 and under),** record of immunization status.
        - ✓ Documentation of advance directive, if completed. The documentation for each visit must include:
            - Date
            - Purpose of visit
            - Diagnosis or medical impression
            - Objective finding
            - Assessment of patient's findings
            - Plan of treatment, diagnostic tests, therapies and other prescribed regimens.
            - Medications prescribed
            - Health education provided

- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

8. The MHN must report EPSDT and other preventive visit compliance rates. For purposes of reporting individuals by age group, the individual's age should be their age on the date of service.

9. Have written case management policies and procedures which include, at a minimum;

   (a) Protocols for
      1. prior approval of services,
      2. access to care coordination,
      3. access to disease management and
      4. hospital discharge planning;
      5. Processes to identify utilization problems and undertake corrective action;
      6. An after-hours call log to practices and help line (or equivalent method) to track utilization and disposition;

   (b) An emergency room log (or equivalent method) to track emergency room utilization reports.

10. Furnish members with approved written information regarding the nature and extent of their rights and responsibilities as a member of the MHN. The minimum information shall include:

    (a) a description of the managed care plan and its physicians,
    (b) Information about benefits and how to obtain them,
    (c) Information on the confidentiality of patient information,
    (d) Grievance and appeal rights,
    (e) Eligibility and enrollment information.

11. Maintain a grievance and appeal system which:

    (a) Has written policies and procedures that are distributed to members. These policies and procedures must comply with 42 CFR 438.400-438.424.
    (b) Informs member they must exhaust the MHN grievance process prior to filing for a state fair hearing, and informs the member of the state fair hearing process and its procedures.(c) Attempts to resolve complaints and grievances through internal mechanisms, whenever possible.
    (c) Maintains a record keeping system for oral and written grievances and records of disposition.
    (d) Provides to SCDHHS, on a quarterly basis, written summaries of the grievances which occurred during the reporting period to include:

- Nature of grievance
- Date of their filing
- Current status
- Resolutions and any resulting corrective action

(e) The MHN shall forward any adverse decisions to SCDHHS for further review/action, upon request by SCDHHS or the MHN Program member.

12. Allow for SCDHHS to evaluate each MHN's compliance with SCDHHS program policies and procedures; identify problem areas; and, monitor the MHN's progress in this effort. At a minimum this must include, but is not limited to, the following:

(a) SCDHHS review and approval of the MHN's written Quality Assurance and Improvement Plan. The MHN must submit any subsequent changes and/or revisions to its Quality Assurance and Improvement Plan to SCDHHS for approval on or before December 15th annually.

(b) SCDHHS review and approval of the MHN's written grievance and appeal policies and procedures. The MHN must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval, prior to implementation.

(c) SCDHHS review of quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.

(d) SCDHHS review of the MHN's reports of grievances, and resolution thereof.

(e) SCDHHS approval of the MHN's Plan of Correction (POC) and monitoring of the disposition of identified items developed as a result of the annual external QA evaluation or any discrepancies found by SCDHHS that require corrective action.

13. External Quality Assurance Review. SCDHHS will provide for an independent review of services provided or arranged by the MHN. The review will be conducted annually by the External Quality Review Organization (EQRO) under contract with SCDHHS. External quality assurance evaluation and EQRO responsibilities shall include:

(a) Conducting an annual review of the Contractor. SCDHHS will convey the final report findings to the MHN, with a request for a POC, if one is warranted.

(b) Assisting the MHN in developing quality of care studies which meet SCDHHS quality indicators, in the event the MHN does not have sufficient resources or expertise to develop a focused quality of care study plan to conduct internal studies.

(c) Conducting workshops and trainings for **MHN** staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

d) SCDHHS will evaluate the MHN's compliance with QA standards through an annual comprehensive QA evaluation. The annual review shall consist of:

1. **Quality Of Care Studies**: a review of medical records by specific criteria which are selected by a statistically valid sampling methodology. The quality of care studies will focus on important aspects of patient care in the clinical settings. SCDHHS selected quality of care studies will require qualified surveyors to:

    - Collect aggregate data pertaining to the populations from which the sample medical records and administrative data will be selected. The quality of care studies will include indicators for prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT examinations. The EPSDT examinations must be broken down by age categories: under one year, one to five years, six to fourteen years and fifteen to twenty years.

    - Abstract data from selected medical records and claims data for childhood immunizations, prenatal care, newborns, asthma, ER utilization and EPSDT examinations.

    - The EQRO will compare findings of quality care studies with findings of the MHN's internal QA programs. The EQRO will also provide analysis and comparison of findings across all MHN's in the program and with findings from other state and national studies performed on similar populations.

2. **Service Access Studies**: A review and evaluation of the MHN's performance of availability and accessibility. Studies will focus on:

    - Emergency room service and utilization
    - Appointment availability and scheduling
    - Referrals
    - Follow up care provided
    - Timeliness of services

3. **Medical Record Survey**: will describe the compliance with medical record uniformity of format, legibility and documentation.

4. **Administrative Survey**: the MHN will be surveyed for administrative policies and procedures, committee structures, committee meeting minutes including governing body, executive, quality assurance and patient advisory. A review of the MHN's credentialing and recredentialing systems (if applicable) and professional contracts, support service contracts, personnel policies, performance evaluation examples, member education information, member grievance and appeal systems, member grievance files, and member disenrollment files.

5. An exit conference will be held to discuss the QA evaluation findings.

6. **QA Evaluation Reports**: the EQRO will submit an individual draft report to SCDHHS 30 calendar days following the onsite visit and an individual MHN final report will be issued by SCDHHS. The results shall be available to participating health care providers, members and potential members. Final EQR results, upon request, must be made available in alternative formats for persons with sensory impairments and must be made available through electronic as well as printed copies. The report shall include, at a minimum, the following:

    - ✓ An assessment of the MHN's strengths and weaknesses
    - ✓ Recommendations for improving the quality of health care services furnished by the MHN;
    - ✓ Comparative information about all MHNs operating within the state; and,
    - ✓ An assessment of the degree to which the MHN has addressed effectively the quality improvement recommendations made during the previous year.

7. Within 30 calendar days (or as specified by SCDHHS) of receipt of the final QA evaluation report, the MHN must submit its Corrective Action Plan to SCDHHS, if deemed necessary by SCDHHS.

8. SCDHHS staff will conduct meetings with the MHN in order to monitor progress with the MHN's POC developed as a result of the annual QA evaluation. The meeting frequency shall be determined by SCDHHS, based on the findings of the annual QA evaluation.

9. If the MHN is accredited by an external organization (e.g., NCQA, URAC, etc.) the MHN shall provide SCDHHS with a copy of its accreditation review findings.

COUNTY NETWORK TERMINATION /TRANSITION PROCESS

The loss of an essential medical provider(s) in a county could result in the loss of the MHN's ability to deliver medical services to its Medicaid beneficiaries. This could result with the MHN losing the county(ies). The MHN could retain the county but because of the loss of the essential provider(s) could result in transitioning the MHN's Medicaid beneficiaries to an alternate medical network in order to retain their continuity of care with their providers.

There are three ways in which the County(s) Network Termination and/or Transition Process can be initiated.

1) SCDHHS Care Management Staff receives verbal and/or written notification from the MHN, along with a copy of the termination letter from the essential provider(s). The copy of the termination letter must be provided to SCDHHS within 24 hours of receipt of essential provider(s)'s intent to terminate its contract(s) with the MHN and no less than 90 days prior to the termination date. All termination must occur at the end of a month.

2) SCDHHS Care Management Staff receives verbal or written notice notification directly from essential provider(s) of its intent to terminate its contract with MHN. SCDHHS will notify the MHN (either verbally or by email) within 24 hours of receipt of the essential provider's intent to terminate.

3) SCDHHS Care Management Staff determines that a MHN County Network provider no longer meets network adequacy access standards. Once SCDHHS determines MHN county network does not meet the network adequacy access standards, it will notify the MHN either verbal or by email.

Upon initiation of the County Network Termination or Transition Process, SCDHHS will schedule the initial County Network Termination or Transition Plan Meeting between SCDHHS Care Management Staff and the MHN. The MHN's transition or termination team must attend the initial meetings. At the initial meeting, the SCDHHS Care Management Staff will determine the specific and critical dates the MHN will be required to submit reports, letters, and other requirements. The MHN will be responsible for creating, maintaining and updating the County Termination/Transition Form (see attached document). The MHN will be required to submit new county (ies) networks using the county network standards found in the P&P Guide. SCDHHS reserves the right to ask for the original contracts (including rates, list of services provided, rates and any other information deemed necessary). SCDHHS may choose to contact the providers listed to verify the accuracy and access capacities of the providers submitted by the MHN. During this process SCDHHS may, at its discretion, halt the assignment of MHN members to the affected county(ies) at anytime. SCDHHS also reserves the right to allow MHN Medicaid beneficiaries to leave the affected plan in order to maintain their continuity of care with their physicians. Any additional cost incurred by the enrollment broker or SCDHHS during of this process will be reimbursed by the MHN.

Project Plan

Project Name	County (ies) Network Terminationand/or Transition Plan Form
Project Description	South Carolina Provider Task Force
Team	MCO & SCDHHS dated **mm/dd/yy**

Key: Overall Status

Green	Not Yet Started or On-Track
Yellow	Cautionary concern; requires close management
Red	Off-Track; immediate course correction required
Complete	Milestone Complete

Overall Project Timeline

CAP #	Task #	Task	Target End Date	Revised Date	Status	Accountability	Comments
1		**Provider Notification of Termination**					
					Not Started		
2		**Member Communications**					
3		**Contingency Plan Milestones**					
					Not Started		
4		**Provider Notification Plan**					
					Not Started		
5		**Website**					

COORDINATION OF MANAGED CARE FRAUD AND ABUSE COMPLAINTS AND REFERRALS

The following set of Policies and Procedures has been developed to govern the disposition of fraud and abuse complaints along with the coordination of activities between SCDHHS and MCOs/MHNs. Their purpose is to establish policy for coordination and referral of complaints made against healthcare providers providing services under a managed care plan and beneficiaries enrolled in a managed care plan, in accordance with 42 CFR 455.

The Division of Program Integrity and the Division of Care Management will work jointly with the managed care plans and medical home networks providing services to the South Carolina Medicaid populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate. SCDHHS receives complaints via three main mechanisms: The fraud hotline toll free number, 1-888-364-3224, the fraud reporting fax line 803-255-8224 or the Program Integrity Extranet portal address.

Coordination Involving DHHS Fraud Hotline Complaints:

- If the DHHS Fraud Hotline receives a complaint about an MCO/MHN beneficiary/member's eligibility for Medicaid, the complaint is referred within three business days to the Division of Program Integrity.
- If DHHS Fraud Hotline receives a complaint about an MCO/MHN beneficiary / member's utilization of benefits, the complaint is referred within three business days to the appropriate Plan, using the DHHS secure portal to share information.
- If DHHS Fraud Hotline receives a complaint about a provider with indications they are in a managed care network, the complaint is referred to Program Integrity and Division of Care Management for preliminary screening for fraud and abuse and/or referral to the appropriate Plan for action.
- The Division of Program Integrity will capture data on complaints made against beneficiaries receiving services under a managed care plan.

Coordination for Fraud and Abuse Complaints Received by Managed Care Organizations:

- If the MCO/MHN receives a complaint about a member's eligibility for Medicaid, the complaint is referred to Program Integrity. The referral is made within three business days using the DHHS secure portal to share information.
- If the MCO/MHN receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the Plan's fraud and abuse / program integrity plan.

- If the MCO/MHN receives a complaint against a health care provider or subcontractor in its network, the MCO/MHN will investigate in accordance with its fraud and abuse/ program integrity plan.

Fraud and Abuse Referrals:

- If a complaint or the findings of a preliminary investigation give the MCO reason to believe that fraud or abuse of the Medicaid program has occurred, the MCO/MHN must immediately (within one working day) report this information to the Division of Program Integrity. Any suspicion or knowledge of fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or subcontractor. The MCO/MHN should submit all relevant information about the case, including its findings and the details of its investigation.

- Upon suspicion of Medicaid fraud on the part of a beneficiary/member enrolled in an MCO/MHN, the MCO/MHN will refer the complaint to the Division of Program Integrity with all supporting evidence so the complaint can be referred to the Medicaid Recipient Fraud Unit in the SC Attorney General's Office. DHHS will refer the case to the Medicaid Recipient Fraud Unit either during its monthly meeting or as soon as possible in urgent cases.

- Upon suspicion of Medicaid fraud on the part of a health care provider paid to provide services to SC Medicaid beneficiaries, either as a participating or non-participating provider in the MCO/MHN, the Division of Program Integrity will refer the case to the Medicaid Fraud Control Unit in the SC Attorney General's Office, either during its monthly meeting or as soon as possible in urgent cases.

- Division of Care Management will send a copy to Program Integrity of any fraud and abuse reports received from the MCOs/MHNs.

- For fraud cases against providers and members either initiated or referred by DHHS, DHHS will inform the MCO/MHN and the Division of Care Management when the case results in a criminal conviction, loss of benefits, and/or exclusion from the Medicaid program.

Excluded Providers:

- Division of Program Integrity will send copies of exclusion letters to the Division of Care Management to share with all Plans, and would likewise notify the Division of Care Management if an excluded provider is reinstated by DHHS.

- These letters will include exclusions based on fraud convictions as well as loss of license, patient abuse, and other reasons.

Information Sharing:

The Secure Portal (extranet) established by Program Integrity should be used for sharing all beneficiary/member and provider information in the context of fraud and abuse reviews and referrals. Each MCO/MHN has an assigned contact person and password. The portal address is:

https://extranet.scdhhs.gov/dhhs/Default.aspx?alias=extranet.scdhhs.gov/dhhs/pi

MHN SHARED SAVINGS FORMULA POLICY

Reimbursement to the Medical Homes Network (the advisory Board and the Care Coordination Services Organization [CSO]) will be based on a shared savings model. The Network will be paid a prospective care coordination fee per member per month. In order to determine the cost savings achieved by a Medical Homes Network, the cost of enrolled Network members will be accumulated on a quarterly basis and will be compared to the cost of covering those same members in a fully insured Medicaid Managed Care Organization (MCO).

Using eligibility and enrollment data, each Network enrollee's member months will be calculated and placed into an age and sex cell developed for Medicaid HMO payment purposes. Member months will be accumulated by age and sex cells and then be applied against the applicable MCO risk adjusted rates to develop the "Medicaid Upper Payment Limit". The "Medicaid Upper Payment Limit" will also include "kicker" payments made for deliveries and births. The risk adjusted "Medicaid Upper Payment Limit" will then be compared against the Medicaid claim expenditures of Network enrollees (including any prospective care coordination fee payments paid to the Care Coordination Services Organization) to determine whether the Network achieved savings. Claim expenditures incurred by Network enrollees will include only those expenditures that are covered under the Medicaid HMO service package (including an adjustment for claims incurred but not reported).

If the Network realizes savings, then the South Carolina Department of Health and Human Services (SCDHHS) will provide an incentive and will reimburse the Network 50% of the savings realized. However, this payment cannot exceed five percent (5%) of the fee for service payments incurred by the network enrollees. The Network's CSO will be responsible for dividing the Network's share of the savings between the participating practices and the CSO, based on the agreement established between the CSO and participating practices. If the Network does not achieve savings, SCDHHS will impose a penalty on the Network and a portion, if not all, of the prospective care coordination fee payments must be refunded to the SCDHHS. Only the prospective care coordination fee payments are at risk since the SCDHHS will continue to directly reimburse the providers on a fee for service basis.

MEDICALLY COMPLEX CHILDREN'S WAIVER PROGRAM POLICIES AND PROCEDURES

Medically Complex Children's Program Overview

The Medically Complex Children's (MCC) Waiver serves participants under the age of 18 who meet the Nursing Facility Level of Care (LOC) or ICF-MR Level of Care and have a chronic physical/health condition that is expected to last longer than 12 months. They must meet defined medical criteria documenting the child's dependence upon comprehensive medical, nursing, and health supervision or intervention. The services offered in this waiver include children's medical day care, respite services to family members, care coordination, and incontinence supplies. If the participant is enrolled with an enhanced primary provider, the waiver will work in conjunction with the Medically Complex Children's Program. The MCC waiver utilizes a Medical Homes Network (MHN), to provide the Enhanced Primary Case Management (EPCM) linkage between the families and the MHN Primary Care Providers (PCP), as well as other service providers.

Providers performing the EPCM service must be a Care Service Organization (CSO). The Care Service Organization may be contracted as a Medically Complex Children's waiver service provider.

All CSO's must meet the following requirements:

a. Three years experience with medically complex children
b. The ability to interface with DHHS quality management and billing processes
c. Software capable of treatment plan development for medically complex children
d. The ability to provide background checks (SLED checks) on all direct care staff
e. The ability to monitor physicians enrolled as enhanced providers to ensure program compliance
f. The ability to provide accounting of all enhanced services provided by the Nurse Care Coordinator and the Enhanced Primary Care Provider in electronic format (preferably Excel) according to format provided by SCDHHS.

Eligibility and Enrollment

Children who are enrolled in the Medically Complex Children's Waiver and enrolled in the Medical Homes Network are eligible to receive enhanced primary case management services (EPCM). The Medically Complex Children's Waiver (MCC) is for children with a serious illness or condition expected to last at least 12 months. This illness or condition makes the child dependent upon comprehensive, medical, nursing and health supervision or intervention as established by state medical criteria. Medical

eligibility to enter the MCC waiver is determined by assessing applicants using the Medical Eligibility Assessment Tool. The purpose of this tool is to provide a consistent, accurate and objective scoring of each child's medical needs. South Carolina Nursing Facility LOC or ICF/MR LOC must also be met.

During the Medically Complex Children's waiver enrollment process, the responsible party for the participant makes the decision to enroll the child into the medical homes network. If the member chooses to enroll into the MHN, the responsible party must call the enrollment broker (Maximus) and/or request enrollment assistance from their Care Coordinator.

Enrollment in the MHN follows the same policy as the general population. Enrollment is voluntary and allowable during the period in which the participant is enrolled in the MCC Waiver. Participants who qualify for the MCC Waiver may choose to enroll in the EPCM. Disenrollment from the EPCM occurs when the participant is terminated from the MCC Waiver. A participant may choose to disenroll voluntarily at any time. Disenrollment is effective at the end of the month.

Enhanced Primary Care Management is provided by a registered pediatric nurse with oversight by the primary care physician. The primary care physician must be 1) specifically credentialed as having the ability to care for medically complex children and 2) be enrolled with the MHN as an enhanced provider for the Medically Complex Children's waiver.

EPCM Physician Services

1. Coordinate chronic and preventive medical management.
2. Conduct health related assessments
    a. Health risk assessment with child
    b. Developmental assessment
    c. Disease specific assessment
3. Ensure "best practice" guidelines are followed for acute illness, prevention and chronic care management.
4. Coordinate specialty care services with other providers including review and interpretation of subspecialty recommendations.
5. Provide continuity of care.
6. Create and maintain an Emergency Medical Plan to be used by EMS personnel and home caregivers.
7. Coordinate medical services, allied health (Occupational Therapy, Physical Therapy, and Speech Therapy) and other EPSDT services.
8. Facilitate participation of health related team members in care planning.
9. Provide family training regarding medical care in the home.
10. Conduct family training to address disease management and, when appropriate, the child's management of their medical condition.
11. Conduct monthly physician evaluations to reassess the plan of care and ensure new needs are addressed through the care coordination process.

EPCM Registered Nurse Care Coordinator Services

1. Coordinate the Care Coordination Plan to ensure integration and coordination of waiver services.
2. Ensure participant/family-centered care.
3. Ensure freedom of choice when educating waiver participants to the choice of providers for services in the Care Coordination Plan.
4. Coordination with other providers (e.g., early intervention, Department of Social Services, etc.)
5. Evaluate and refer to appropriate community/state programs to meet care needs.
6. Facilitate transportation to Medicaid services.
7. Assure health, safety and welfare as required in the 1915c waiver, including:
    a. Ongoing assessment of home environment to address barriers for caring for the child in the home.
    b. Coordinate with Department of Social Services – foster care services.
8. Assess member satisfaction with providers.
9. Re-evaluate Care Coordination Plan on an on-going basis and provide recommendations for amendments.
10. Conduct discharge planning for participants, with recommendations for termination or transfer from the MCC waiver, as appropriate.

EPCM Provider Requirements

The physician will:

1. Conduct at minimum, a monthly assessment of the patient;
2. Perform an initial assessment to include sign off of care coordination plan;
3. Complete a monthly assessment, including evaluation and updating of the care plan, and provide this information to the MHN;
4. Provide for 24 hour access, seven days a week;
5. Provide the MHN with administrative notification of all services;
6. Participate in the quality management program, including peer review process of medical records;
7. Establish a clinical program primary contact with the MHN;
8. Maintain hospital privileges;
9. Participate in a credentialing process, including provision of credentialing documents upon request;
10. Provide an EPSDT Screening for any foster child transferred to their practice within 24 hours of a DSS request;
11. Participate in the bi-annual interdisciplinary Team treatment meeting;
12. Document enhanced primary care services in accordance with state defined reporting needs and provide to CSO in electronic format monthly.

CSO Reporting requirements for Enhanced Primary Care and Enhanced Primary Case Management

Monthly, the CSO must provide an Excel spreadsheet documenting the services provided by the enhanced primary care provider and the CSO's nurse case manager as part of the monthly MCC enhanced care coordination fee and are not otherwise billed to Medicaid. The file must include the following information: Participant Name, Participant Medicaid Number, CPT Code, Description of Service, Date of Service, Group Provider Number, Provider Number, Provider Name. The format of the Excel spreadsheet and the definition of each of the fields and accepted CPT codes are provided in the Index of Required Files, Reports and Forms.

INDEX OF REQUIRED FILES, REPORTS AND FORMS

This chart is a summary listing of 1) all files/reports to be submitted by MHNs to SCHHHS, 2) all files/reports to be submitted by SCDHHS to MHNs and 3) all applicable SCDHHS forms to be used by MHNs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing pre-defined data elements or record of information and a form is defined as a document used to collect or report information. The medium of all files and reports shall be electronic and follow the specifications noted in the Software Reporting Requirement of the 2010 MHN Contract **or** MMIS guidelines and requirements (as applicable).

All files/reports with a frequency of "monthly" are due no later than the 15th (fifteenth) day after the end of the reporting month. All files/reports with a quarterly frequency are due no later than the 30th (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90th (ninetieth) day after the end of the reporting year period.

General Instructions and Information Technology Requirements			
Information Technology Standards for MHN		Page 68	
Data Transmission Requirements		Page 75	
Security Requirements For Users of SCDHHS's Computer Systems		Page 76	

MHN Reports to SCDHHS	Frequency	Format Specifications	Recipient
Network Providers and Subcontractors Listing Spreadsheet Requirements	Monthly	Page 79	Department of Managed Care, Quality Programs
After-Hours Calls Log (Practices and Help Line)	Quarterly	Developed by MHN	Department of Managed Care, Quality

MHN Reports to SCDHHS	Frequency	Format Specifications	Recipient
			Programs
New Member Contact Log	Quarterly	Developed by MHN	Department of Managed Care, Quality Programs
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Page 80	Department of Managed Care Nurse Administrator for Quality
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Page 81	Department of Managed Care, Quality Programs
Medically Complex Children's Waiver Documentation of Services included in the Enhanced Primary Care Rates - Documentation Format	Reported Monthly	Page 82	MCC program staff
Case Management Plan	Annually	Developed by MHN and SCDHHS	Department of Managed Care, Quality Programs
Quality Assurance (QA) A. QA Plan B. QA Plan of Correction	 As Required As Required	 See Contract §11, P&P Guide See Contract §11,	 Department of Managed

MHN Reports to SCDHHS	Frequency	Format Specifications	Recipient
C. Quality Indicators D. Reporting Measures	Quarterly Annually	P&P Guide	Care, Quality Programs
Member Satisfaction Survey	Annually	Instrument and Survey Results	Department of Managed Care, Quality Programs
Performance Standards – PCP Compliance with After-Hours Coverage Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care Quality Programs
Performance Standards – PCP Compliance with Appointment Availability Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care, Quality Programs
Performance Standards – PCP Compliance with Office Visit Times Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care, Quality Programs

SCDHHS Files to MHNs	Frequency	Format Specifications	Recipient
Managed Care MLE Record Description	Monthly	Page 85	MHN
Claims Record Description (	Monthly	Page 88	MHN
MHN Recipient Record Layout	Monthly	Page 97	MHN
MCO/MHN Recipient Review Recertification File	Monthly	Page 102	MHN
MHN Record Description Reference File	Monthly	Page 106	MHN
MCO/MHN/MAXIMUS Sync File Layout	At least monthly	Page 110	MHN
Appendices			
County Listing		Page 113	
Provider Practice Specialty Table		Page 114	
Bills of Rights		Page 117	
Forms Listing			
Plan Initiated Disenrollment Request Form SCDHHS Request for Medicaid ID Number Form (SCDHHS 1716 ME)		Page 122 Page 123	

GENERAL INSTRUCTIONS AND INFORMATION TECHNOLOGY REQUIREMENTS

INFORMATION TECHNOLOGY STANDARDS FOR MEDICAL HOME NETWORKS

1. General Characteristics

   The MHN Information Technology (IT) System must support the many functions of the MHN program. It will contain highly confidential data subject to state and federal laws and regulations. Although the ultimate responsibility for patient care remains with the physician or other provider, lost or inaccurate data can impede the ability of the MHN to support the provision of optimal care by the provider.

   The MHN IT System must meet the following general characteristics:

   - Compliance with Law, Regulations and Accreditation Standards – The MHN's data system must comply with all applicable laws, accreditation standards and regulations for the handling of confidential health information. This includes the requirements of HIPAA for Protected Health Information; HIPAA requires assurance of privacy and security, and mandates the use of certain formats for data transfers, among other requirements.

   - Security – MHN IT systems must be secure from compromise by internal and external threats.

   - Accuracy – The data system must maintain data accurately and without corruption.

   - Stability and Reliability – The data system must be stable, not subject to sudden failures or unreliable behavior. It is recommended that systems have an activity log as a documentation mechanism.

   - Robustness – The data system must have the capacity to handle very large data sets without suffering from undue degradation of performance.

   - Redundancy – At a minimum, the data sets must be backed up on a scheduled basis, and the backup copies stored on separate media in a separate geographic location from the main data center.

2. Systems

   The optimal system will provide access to data via secure direct client access and secure web-based access to the data. The system must be able to import, store, process, and export large volumes of data in an acceptable amount of time. Response times for online query will be sub-second. Interface speeds will be in accordance with current industry standards. The system's architecture must be kept current with industry standards.

Please note that all interface layouts and EDI communications protocols will be dictated by SCDHHS. All EDI communications must be encrypted to meet or exceed HIPAA standards.

In general, MHN programs will require two different types of systems: Transaction Systems, which manage the day-to-day operations of the MHN program with real-time interaction; and Reporting and Analysis Systems, which provide the reports for monitoring and analyzing the performance of the program, recognizing trends, and identifying problems and opportunities.

Transaction Systems

Transaction systems allow quick access to needed data for support of daily tasks. MHNs require the following Transaction Systems:

1. Enrollment System

   The MHN must be able to accurately track which beneficiaries are enrolled in the program at any given time. The Enrollment System must support storage and retrieval of at least the following information for each Member:

   Name
   Medicaid ID #
   Address
   Date Of Birth
   Primary Physician
   Enrollment Status (Enrolled, Disenrolled, etc.)
   Date of Enrollment
   Date of Disenrollment

2. Medical Management System

   The Medical Management System must support, at a minimum, the following functions:

   a. Service Referral Management

      The Primary Care Case Management (PCCM) model embodied in the MHN program requires that members receive a referral from their primary physician for non-emergent care from other providers. Therefore, the MHN must have an information system that can record, track, and verify referrals in a real time manner. The system must also support the functions of preauthorization and post-authorization in a similar way.

The Service Referral System must record, at a minimum:

- ✓ Name of the member being referred
- ✓ Member's Medicaid ID
- ✓ Identity of the referring doctor
- ✓ Identity of the provider being referred to
- ✓ Condition or diagnosis of the patient for which referral is sought
- ✓ Service being requested
- ✓ Time limit or number of visits authorized
- ✓ Referral or authorization identifying number

The system must have functionality that immediately identifies attempted referrals that are duplicates of existing still-valid referrals, or that violate medical policy in some way (referrals to providers who are not Medicaid providers, for example).

b. Care Management

Once high-risk, high-utilizing, or vulnerable patients are identified, the MHN program is responsible for monitoring the care of such patients. For this, a system is required that supports ongoing care management by clinical personnel. The care management system must include at least the following functions:

Intake – the ability to enroll a new patient into the care management process. Information collected must include patient demographics, diagnoses and conditions, treating physicians, medications, a current problem list, and contact information for all relevant providers and family.

Contact Recording – the ability to record the relevant information regarding each contact (for example, telephonic, mailings, case management, etc.) with the patient, their providers, or others associated with the case. Contact recording and retrieval of records from previous contacts must be simple, accurate and efficient, so it can proceed in real time (for example, during a telephone call).

Reminders – the ability to prompt the care manager/care management team to perform a task (such as, call the patient) at some previously decided interval (such as, one week from the last contact).

Best Practice Protocols – the ability to call up relevant clinical protocols representing best practices for the management of both common and complex diseases.

Acuity Levels – the ability to track acuity levels of patients as well as "per diagnosis" acuity and stability.

c. Pharmacy Management and Utilization Review

The MHN program must support optimal regimens of medications for members. An education mechanism must be established for use by physicians to provide information on the most clinically effective and cost effective drugs for each condition. At a minimum, the MHN program must provide online access for physicians to this pharmacy education information. In addition, the program should monitor member prescription trends for medical and non-medical uses. Examples include over/inappropriate prescription and prescription drug abuse.

d. Quality Management

The MHN program must assure and improve the quality of care while maximizing financial resources. The information system must support quality management functions by:

1. Tracking industry-standard quality measures, (such as URAC and HEDIS);
2. Tracking complaints by providers and members, with recording of the process of investigating the complaint, as well as recording the result of the investigation and any corrective actions taken; and
3. Tracking member satisfaction and provider satisfaction measures.

e. Patient Education

The MHN program supports healthy behaviors by members and helps educate them on relevant aspects of their medical conditions, medications, planned tests or procedures. At a minimum, the MHN information system makes effective patient education materials available online for physicians and/or patients. For high priority disease states, as determined by SCDHHS, the education systems should support identification of members who have the disease(s) or are at high risk and provide specialized education resources.

3. Provider Service System

The MHN program requires the recruitment and education of providers, and collaboration with and among them. The Provider Service System must include the following functions, at a minimum:

a. Contact Management – storage and retrieval of provider contact information, plus tracking of all contacts with a provider in the course of recruitment, contracting, in-service training, education, and problem resolution.
b. Practice Management Information – storage and retrieval of locations, office hours, age restrictions, physical accessibility, etc.

c. Contract Information - storage and retrieval of information on the provider's contracts with SCDHHS and with any MHN Care Coordination organization.
d. Credentialing Information - storage and retrieval of information on provider's medical specialty, licensure, malpractice insurance, verification sources, etc.

4. Financial System

The MHN program will potentially handle significant sums of Medicaid funds, in administrative fees and shared savings payments. It must possess adequate financial systems for the purposes of accounting, payments, audit and control. In addition, the MHN program may pay out performance bonuses to providers, and must have sufficiently powerful and flexible financial systems to calculate, pay, and account for such bonuses. SCDHHS anticipates the MHN program will become the claims processor for the physicians in the network: receiving claims (electronically and via hard copy), processing claims, and paying claims. The financial system must be able to expand to easily accommodate this function without causing any disruption to the participating providers.

The MHN Financial System must, at a minimum, include the following functions:

- Accounting
- Accounts Payable
- Accounts Receivable
- Provider accounting for calculation and payment of performance bonuses

Reporting and Analysis Systems

MHNs must be able to produce a wide range of reports for both internal and external use, and be able to perform sophisticated analyses on very large sets of claims and enrollment data in order to optimally support the provision of quality, cost-effective care by contracted providers. A Reporting and Analysis System will perform these functions.

The MHN Reporting and Analysis System should have the following general design elements:

1. A nationally recognized "data warehouse" and prediction tool that uses a relational database, (typically based on Structured Query Language) of sufficient capability.

2. A "data warehouse" that has sufficient capabilities for data import and data export. It will receive data from multiple distinct sources, and must be able to output data into a variety of standard formats, to enable end-user

presentation and manipulation in office productivity applications such as spreadsheets and PC databases.

3. A “data warehouse” which contains all relevant data needed for the MHN to fulfill its reporting and analysis functions, and include the ability to receive and incorporate data from enrollment, claims, medical management and financial sub-systems. The minimum data set should include:

   - Member demographics
   - Claims information, including at least:

     Date of Service
     Service/Medication Provided
     Quantity of Service/Medication
     Provider of Service
     Place of Service
     Diagnosis
     Payment
     Referring/Prescribing Provider
     Referral/Authorization Code
     Date Paid
     Claim Identification Number
     Enrollment/Disenrollment Dates
     Primary Care Provider

   - Primary Care Provider information
   - Information on other providers
   - Referral/Authorization data
   - Case Management data
   - Drug Utilization Data
   - Quality Management data
   - Financial data, including information on performance bonuses paid

The MHN Reporting and Analysis System should include adequate tools to perform report-generation and analysis of patterns and trends. The reporting function must include, at a minimum:

1. A comprehensive set of standard reports, including, at a minimum:

   a. Enrollment reports, including monthly reports on currently enrolled, newly enrolled, and disenrolled beneficiaries.

   b. Referral/authorization reports, including monthly reports on members’ referred/authorized for services.

   c. Utilization reports, including monthly reports on hospital usage,

Emergency Room usage, and medication usage.

d. Care management reports, including monthly reports on members with target diagnoses, members in care management, utilization by target disease and care plan development and education provided to the member.

e. Quality management reports, including tracking of industry standard measures, re-admission data, member satisfaction and provider satisfaction.

f. Health maintenance reports, including quarterly reports on members who have not had recommended health maintenance interventions (such as Child Health Checkup, or Diabetic Eye Exam) within prescribed or recommended time frames.

g. Provider profiling, report card, and performance bonus reports.

h. Reports must have the ability to be run on a "to be determined" schedule.

2. In addition to a comprehensive set of standard reports, the data system should include strong tools for generating ad hoc reports as the need arises, including, at a minimum:

a. Ability to output results as tables and/or graphs of various types, as chosen by the user;
b. Ability for the user to make comparisons, sort lists, drill down, roll up/combine, and identify results that exceed or fall below some threshold; and
c. Ability to import and export data in various common formats for use in office productivity tools such as spreadsheets and databases.

Data Transmission Requirements

The State Of South Carolina, Department of Health And Human Services (SCDHHS), utilizes the product Connect: Direct (C:D) to support EDI utilizing the TCP/IP protocol.

The State requires C:D FTP connections to be on a specified port. It is the responsibility of the connecting agency/entity to provide access through their firewall, on a designated port.

CDFTP+ provides a simple, reliable way to transfer files securely between a C:D server, at a central processing center, and remote sites. This is accomplished either through a graphical user interface (GUI), or through a command line interface that accepts common FTP commands and scripts.

- C:D FTP+ has checkpoint and restart capability.
- FTP+ is utilized at SCDHHS, on a mainframe, with Secure+, a data encryption product.
- Data integrity checking is utilized ensuring integrity of the transferred data and verifies that no data is lost during transmission.
- CDFTP+, the PC client software, is provided at no cost.

After the appropriate security and data sharing agreements are completed a connection with SCDHHS can be established. Technicians from both entities will be required to establish and test the C:D connection. At the time of connection the appropriate software, keys files, documentation, E-mail addresses, contact information, and file naming conventions will be exchanged, by SCDHHS and the agency/entity technicians, to ensure a secure connection is established.

SECURITY REQUIREMENTS FOR USERS OF SCDHHS'S COMPUTER SYSTEMS

SCDHHS uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of The State of South Carolina programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in the State of South Carolina computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. SCDHHS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of SCDHHS's computerized information and resources. SCDHHS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to SCDHHS computer systems must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Do not browse or use SCDHHS data files for unauthorized or illegal purposes.
- Do not use SCDHHS data files for private gain or to misrepresent yourself or SCDHHS.
- Do not make any disclosure of SCDHHS data that is not specifically authorized.
- Do not duplicate SCDHHS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter SCDHHS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of SCDHHS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from the State of South Carolina Service, depending upon the seriousness of the offense. In addition, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

Organization Contact Signature: _____Date: _____

HHS Approver Signature: _____Date: _____

MHN REPORTS TO SCDHHS

Model Attestation Letter

(Company Letter Head)
Attestation for Reports

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the _____ Report(s) is accurate, true, and complete.
I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages as outlined in Section 13.3 of the contract or sanctions and/or fines as outlined in Section 13.5 of the contract.

_____
_____
Signature/Title Date

MHN NETWORK PROVIDER and SUBCONTRACTOR LISTING SPREADSHEET REQUIREMENTS

Provide the following information regarding network providers:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. Street Address, City, State, Zip Code, Telephone Number of Practice/Provider - Self-

4. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number under which the provider/practitioner is enrolled. Also include the NPI, if available.

5. Specialty Code - Indicate the practitioner's specialty using the Medicaid Specialty Codes.

6. New Patient - Indicate whether or not the provider is accepting new patients.

7. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 18, indicate < 18; if a physician only sees patients age 13 or above, indicate ≥ 13.

8. Contract Name/Number – Indicate which MHN subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.

9. Contract Begin Date – Indicate the date the contract became effective.

10. Contract Termination Date – Indicate the date the contract ended.

11. County Served – Indicate which county or counties the provider's office is located serves by placing an "X" in the appropriate column. See County Listing. Do so by listing all 46 counties in alphabetical order (one column per county) and placing an "X" in each appropriate column, indicating the providers' location".

On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month. For these tabs, please provide the information requested in items 1-11 above.

Grievance Log with Summary Information

For each grievance, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the grievance was received by the MHN.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MHN by SCDHHS.

Summary of Grievance: Give a brief description of the member's grievance. Include enough information to provide SCDHHS with an understanding of the member's grievance.

Current Status: Indicate the current status of the grievance at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc.

Resolution/Response Given: Indicate the resolution, the response given to the member and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the grievance was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MHN as a result of the grievance.

Plan Name (Medicaid Number)
Grievance Log
Month/Year: _____

Date Filed	Member Name	Member Number	Summary of Grievance	Current Status	Resolution/ Response Given	Resulting Corrective Action

Appeals Log with Summary Information

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the appeal was received by the MHN.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MHN by SCDHHS.

Summary of Appeal: Give a brief description of the member's appeal. Include enough information to provide SCDHHS with an understanding of the member's appeal.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc.

Resolution/Response Given: Indicate the resolution, the response given to the member and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the appeal was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MHN as a result of the appeal.

Plan Name (Medicaid Number)
Appeals Log
Month/Year: _____

Date Filed	Member Name	Member Number	Summary of Appeal	Current Status	Resolution/ Response Given	Resulting Corrective Action

Medically Complex Children's Waiver
Documentation of Services included in the Enhanced Primary Care Rate

Excel File Format Description

Field Name	Field Definition
Participant Name	Name of Waiver participant
Medinum	Medicaid number of Wavier participant
CPT Code	See allowable CPT Codes and definitions below
Description	Indicate who was involved in the service. For example: 99373 (Telephone Consult): List with whom the primary care provider consulted (i.e., parent/caregiver, orthopedic surgeon, ophthalmologist, ENT, neurologists, nutritionist, etc.) 99366 (Team Conference with family present): Indicate if physician. If an allied health professional was paid to attend the conference, list the professional who was paid (e.g., PT, OT, Speech, Nutritionist, etc.). Use a separate line for each professional attending. Follow the same rule for codes 99367 and 99368.
Date of Service	Date service provided
Group Provider Number	Practice number
Provider Number	Individual Physician/therapist NPI number
Provider Name (Physician)	Physician/therapist name (not practice)

Medically Complex Children's Waiver
Enhanced Primary Care Rate – Approved CPT Codes

99340: **Care Plan Oversight (Physician)**
Use this CPT code for care plan oversight activities for physician supervision of an established patient:
Individual physician supervision of a patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month.
This code is calculated in the rate @1.5 per month. The physician can bill for the primary care visit, but cannot bill MMIS for the Care Plan Oversight.

99ECC **Care Plan Oversight (Nurse):** ***This is not a valid CPT code and is to be used only for this reporting mechanism for the MCC Waiver.*** **Use this code for care plan oversight activities of the CSO Nurse Care Coordinator for care coordination activities not otherwise billed through Care Call.**

99373: **Telephone Consult:** This code is used to document a telephone call by a physician to the parent/caregiver or for consultation or medical management with other health care professional (e.g., specialists, healthcare providers, therapists, etc.) to coordinate a management care plan, to discuss test results in detail, to discuss and evaluate new information and details, or to initiate a new plan of care.. This code is included in the rate at four (4) consults per month.

Team Conference is included to pay for professionals other than the physician (e.g., PT, OT, Speech) to participate in the conference.

99366: Team Conference Face-to-Face (family present). Use this code for physician and allied health professionals (e.g., PT, OT, Speech) when family attends conference.

99367: Team Conference, physician (physician present, family not present)

99368: Team Conference, non-physician (family not present)

SCDHHS FILES TO MHN

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL HOMES NETWORK RECORD DESCRIPTION

Member Listing Extract Record

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	MLE-RECORD-TYPE	1	1	1	Internally used, should always = 'C'
2	MLE-CODE	1	2	2	A – AUTO ENROLLED R - RETROACTIVE N - NEW P – PREVIOUSLY ENROLLED WITH SAME PHYSICIAN C - CONTINUING D - DISENROLLED
3	MLE-PROV-NO	6	3	8	Physician recipient is enrolled with. File 4 – Provider File, and File 8 – Provider Group Affiliation
4	MLE-PROV-NAME	26	9	34	
5	MLE-CAREOF	26	35	60	
6	MLE-STREET	26	61	86	
7	MLE-CITY	20	87	106	
8	MLE-STATE	2	107	108	
9	MLE-ZIP	9	109	117	
10	MLE-RECIP-NO	10	118	127	Recipient identifying Medicaid number.
11	MLE-RECIP-LAST-NAME	17	128	144	Recipient identifying name/address
12	MLE-RECIP-FIRST-NAME	14	145	158	
13	MLE-RECIP-MI	1	159	159	
14	MLE-ADDR-CARE-OF	25	160	184	
15	MLE-ADDR-STREET	25	185	209	
16	MLE-ADDR-CITY & STATE	25	210	234	
17	MLE-ADDR-ZIP	9	235	243	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
18	MLE-ADDR-PHONE	7	244	250	
19	MLE-COUNTY	2	251	252	
20	MLE-RECIP-AGE	3	253	255	
21	MLE-RECIP-SEX	1	256	256	M - MALE F - FEMALE U - UNKNOWN
22	MLE-RECIP-PAY-CAT	2	257	258	Recipient category of eligibility: Table 01 – Assist Pay
23	MLE-RECIP-DOB.	8	259	266	CCYYMMDD
24	MLE-ENROLL-DATE	6	267	272	YYMMDD – could be spaces for disenrolled
25	MLE-DISENROLL-DATE	6	273	278	YYMMDD – spaces if still enrolled
26	MLE-DISENROLL-REASON	2	279	280	01 - NO LONGER IN HMO PROGRAM 02 - TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER 03 - MEDICAID ELIGIBILITY TERMINATED 04 - HAS MEDICARE OR IS >= 65 YEARS OF AGE 05 - CHANGE TO NON MEDICAID PAYMENT CATEGORY 06 - MANAGED CARE PROVIDER TERMINATED 07 - OCWI (PEP AND PAYMENT CATEGORY 87) 08 - RECIPIENT HAS TPL HMO POLICY Will be spaces for enrolled recipients.
27	MLE-PREMIUM-RATE	9	281	289	Amount of Premium paid Will be zeroes for disenrolled recipients
28	MLE-PREM-DATE.	6	290	295	CCYYMM – Month for which the premium is paid. Could be spaces for disenrolled recipients.
29	MLE-REVIEW-DATE	8	296	303	CCYYMMDD – Date recipient will be reviewed for eligibility and/or managed care enrollment. Could be spaces for

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
					disenrolled recipients
30	FILLER (reserved for future use)	1	304	304	
31	MLE-SSN	9	305	313	Member's social security number
32	MLE-BOARD-NUMBER	6	314	319	Medical Home Board number
33	MLE-RECIP-AREA-CODE	3	320	322	Recipients Area Code
34	MLE-FAMILY-NO	8	323	330	Family # for recipient.
34	FILLER (reserved for future use)	10	331	340	Filler, reserved for future use

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CLAIMS RECORD DESCRIPTION
Medical Home Network or Managed Care Organization

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Claim-Indicator	1	12	12		'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files 'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files. 'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information.
4.	Filler	1	13	13	C	
5.	Recipient Pay Category	2	14	15	C	Table 01 – Assistance Pay Category – at time of claim
6.	Filler	1	16	16		
7.	Recipient RSP code1	1	17	17	C	Table 02 – RSP (Recipient Special Program) Codes
8.	Filler	1	18	18		
9.	Recipient RSP code2	1	19	19	C	Table 02 - Note: If any of the RSP fields (3-9) = '5'
10.	Filler	1	20	20		then the recipient was in a MHN
11.	Recipient RSP code3	1	21	21	C	Table 02 at the date of service of this claim.
12.	Filler	1	22	22		
13.	Recipient RSP code4	1	23	23	C	Table 02
14.	Filler	1	24	24		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
15.	Recipient RSP code5	1	25	25	C	Table 02
16.	Filler	1	26	26		
17.	Recipient RSP code6	1	27	27	C	Table 02
18.	Filler	1	28	28		
19.	Recipient County	2	29	30	C	Table 03 - County Codes - residence county at time of claim
20.	Filler	1	31	31		
21.	Recipient Qualifying Category	2	32	33	C	Table 04 - Qualifying Category – at time of claim
22.	Filler	1	34	34		
23.	Recipient Date of Birth	6	35	40	C	YYMMDD
24.	Filler	1	41	41		
25.	Recipient Sex	1	42	42	C	Table 12 – Gender
26.	Filler	1	43	43		
27.	Claim Control #	16	44	59	C	
28.	Filler	1	60	60		
29.	Claim Type	1	61	61	C	see table 5 – Claim Type
30.	Filler	1	62	62		
31.	Type of Bill	1	63	63	C	M=Medicaid, X=Crossover
32.	Filler	1	64	64		
33.	From Date of Service	6	65	70	C	YYMMDD Claim Type Z: Admit Date Claim Type J: Premium Date Claim Type G: First DOS = From All others: Date of Service= FROM
34.	Filler	1	71	71		
35.	To Date of Service	6	72	77	C	YYMMDD Claim Type Z: Discharge Date = TO Claim Type J: Effective Date of any change Claim Type G: First DOS = TO All others: Date of Service=TO

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
36.	Filler	1	78	78		
37.	Date Paid	6	79	84	C	YYMMDD
38.	Filler	1	85	85		
39.	Paid Amount	10	86	95	N	9999999.99 Claim Type D,Z,J,G: Total Paid – Claim All others: Total Paid – Line
40.	Filler	1	96	96		
41.	Charged Amount	10	97	106	N	9999999.99 Claim Type D,Z,J,G: Total Charged – Claim All others: Total Charged for Line
42.	Filler	1	107	107		
43.	Amt received - other (TPL)	10	108	117	N	9999999.99 Claim Type G (Nursing Home): Patient income applied to bill. All others claim types – Any other amt received. CLAIM Level field, not line i.e. for HIC & Dental, use only 1 per claim
44.	Filler	1	118	118		
45.	Clm Copayment Amount	8	119	126	N	99999.99 A(HIC), (B)Dental - Line Level D(Drug), (Z) UB92 - Claim Level
46.	Filler	1	127	127		
47.	Line number	2	128	129	C	A (HIC) B (Dental) - Line number D - Medically necessary (field 1) Values: Y=YES, N or Blank or zero = NO All others: not used, will be 01
48.	Filler	1	130	130		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
49.	Payment Message Indicator	1	131	131	C	Table 16 – Payment Messages HIC – Payment Message indicator (determines how surgical claim is paid. DRUG – Brand name medically necessary code DENTAL – Oral surgery indicator UB92 - Reimbursement Type
50.	Filler	1	132	132		
51.	Service Code	11	133	143	C	A (HIC), B(DENTAL) – Procedure Subfile & Code (first 6 bytes) Subfile = Table 6, Procedure Code – File 1 D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code Z (UB92) – attending MD UPIN if present
52.	Filler	1	144	144		
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z
54.	Filler	1	148	148		
55.	Place of service	2	149	150	C	A (HIC) - 2 byte place of service Table 8 B (DENT) - 1 byte place of service Table 8 Z (UB92) - Patient Status Table 8Z All others – not used
56.	Filler	1	151	151		
57.	Units	4	152	155	N	A (HIC), B (DENT) - units D (DRUG) – Quantity Z (UB92) - Inpatient - Covered Days G (NH) - Total days All Others – not used
58.	Filler	1	156	156		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
59.	Diagnosis code Primary	6	157	162	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) - Therapeutic Class if present – Table 19
60.	Filler	1	163	163		
61.	Diagnosis code Second	6	164	169	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) – Generic Class if present
62.	Filler	1	170	170		
63.	Diagnosis code Admit	6	171	176	C	Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes
64.	Filler	1	177	177		
65.	Funding code-1	2	178	179	C	File # 3 Fund Codes – valid for all claim types
66.	Filler	1	180	180		
67.	Funding code-2	2	181	182	C	File # 3 Fund Codes - valid only for hospital claims
68.	Filler	1	183	183		
69.	Funding code-3	2	184	185	C	File # 3 Fund Codes - valid only for hospital claims
70.	Filler	1	186	186		
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations
72.	Filler	1	193	193		
73.	Paid Provider Type	2	194	195	C	Table # 9 – Provider Types
74.	Filler	1	196	196		
75.	Paid Provider Specialty	2	197	198	C	Table # 10 – Provider Specialty
76.	Filler	1	199	199		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
77.	Servicing Provider #	6	200	205		A (HIC) and B (DENT) – Provider of services All others – same as Paid Provider File # 4 and # 8 – Provider and Provider Group Affiliations
78.	Filler	1	206	206		
79.	Servicing Prov Type	2	207	208	C	A (HIC) and B (DENT): Provider of services All others – same as Paid Provider Table # 9 – Provider Types
80.	Filler	1	209	209		
81.	Servicing Prov Specialty	2	210	211	C	For A (HIC) and B (DENT) – provider of services UB92, BIO – Category of Service of Paid Provider – Table 20 All others – same as Paid Provider Table # 10 – Provider Specialty
82.	Filler	1	212	212		
83.	Prescriber ID	6	213	218	C	Prescriber Medicaid # if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
84.	Filler	1	219	219		
85.	Prescriber ID-Type	2	220	221	C	Prescriber Provider Type if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
86.	Filler	1	222	222		
87.	Prescriber ID-SSN	9	223	231		Prescriber SSN if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:
88.	Filler	1	232	232	C	
89.	Prescriber ID-NAPB	7	233	239	C	Prescriber NABP if present. Note: All the prescriber fields (42-45) are unreliable They are reserved for future use Note:
90.	Filler	1	240	240		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
91.	Refill # (blank if orig)	2	241	242	C	Blank or zeroes if original RX, otherwise # refills
92.	Filler	1	243	243		
93.	Days Supply	3	244	246	N	
94.	Filler	1	247	247		
95.	DRG	3	248	250	C	File # 6 – DRG Codes
96.	Filler	1	251	251		
97.	Outpt Visit Type	1	252	252	C	E=emergency room , Table # 11 Outpatient visit codes
98.	Filler	1	253	253		
99.	ICD9 Surgical Code 1	6	254	259	C	File # 7, Surgical Codes
100.	Filler	1	260	260		
101.	ICD9 Surgical Code 2	6	261	266	C	File # 7, Surgical Codes
102.	Filler	1	267	267		
103.	ER Revenue Code	3	268	270	C	ER Revenue code. N/A unless field #49 is equal to "E" (i.e. the claim is an ER claim)
104.	Filler	1	271	271		
105.	Provider Own Reference #	15	272	286	C	A (HIC) B (DENT) G (NH) – Provider own reference D (DRUG) – Prescription number Z (UB92) – Medical Records number
106.	Filler	1	287	287		
107.	Paid Provider Ownership Code	3	288	290	C	Table #18 – Provider Ownership
108.	Filler	1	291	291		
109.	Prescriber Number	10	292	301	C	Match to file on DHHS Drug Website # assigned to a physician which is used to identify the prescriber.
110.	Filler	1	302	302		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
111.	HIC- Authorization Number	8	303	310	C	Prior authorization # for Claim Type A
112.	Filler	1	311	311		
113.	Provider County	2	312	313	C	Provider county Table 3 – County codes
114.	Filler	1	314	314		
115.	Prior Authorization Number 1	13	315	327	C	Prior Authorization # for Claim Type B
116.	Filler	1	328	328		
117.	Prior Authorization Number 2	7	329	335	C	Prior Authorization number 2
118.	Filler	1	336	336		
119.	MHN/MCO Provider number	6	337	342	C	For sure claims (PCCM indicator = M or H) this is the MHN or MCO the recipient is a member of at the date of service. For history claims (PCCM indicator = S) this is the MHN or MCO the recipient is a current member of.
120.	Filler	1	343	343		
121.	Check Number	7	344	350	C	
122.	Filler	1	351	351		
123.	Gatekeeper Physician	6	352	357	C	Valid for MHN sure claims only (PCCM indicator = M) – This is the physician number of the gatekeeper at the date of service of the claim.
124.	Filler	3	358	360		Reserved for future use

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MHN RECIPIENT RECORD LAYOUT

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Recipient Select Indicator	1	12	12	C	G-in program already (RSP present), P-possible eligible
4.	Filler	1	13	13		
5.	Recipient Status at Beginning of Current Month	1	14	14	C	N = Newly eligible this month C = Continuing eligibility U = Not eligible at beginning of current month, eligible in prior month P = Possible eligible
6.	Filler	1	15	15		
7.	Date Record Created	8	16	23	C	CCYYMMDD Date this record created
8.	Filler	1	24	24		
9.	Recipient RSP indicator	1	25	25	C	Y-has a RSP record, N-no RSP record
10.	Filler	1	26	26		
11.	Race	2	27	28	C	Table 13 Recipient Race
12.	Filler	1	29	29		
13.	Assistance Pay Cat when Eligible	2	30	31	C	Table 01 Assist Pay Category (pay category at time of eligibility)
14.	Filler	1	32	32		
15.	Recipient County where eligible	2	33	34	C	Table 03 County Codes
16.	Filler	1	35	35		
17.	Recipient # eligibility occurrences	2	36	37	N	# Eligibility occurrences until eligible during reporting period.
18.	Filler	1	38	38		
19.	Current Assist Pay Category	2	39	40	C	Table 01 Assist Pay Category (current pay category)
20.	Filler	1	41	41		
21.	Recipient Qualifying Category	2	42	43	C	Table 04 Qualifying Category

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
22.	Filler	1	44	44		
23.	Recipient Gender	1	45	45	C	Table 12 Gender
24.	Filler	3	46	48		
25.	Recipient Living Arrangement	4	49	52	C	Table 14 Living Arrangement
26.	Filler	1	53	53		
27.	Recipient Facility Type	3	54	56	C	Table 15 Facility Type
28.	Filler	1	57	57		
29.	Address (Care of)	25	58	82	C	
30.	Filler	1	83	83		
31.	Address Line 2-Street	25	84	108	C	
32.	Filler	1	109	109		
33.	Address Line 3-City/State	25	110	134	C	
34.	Filler	1	135	135		
35.	Address - Zip Code	9	136	144	C	
36.	Filler	1	145	145		
37.	Phone Area Code	3	146	148	C	
38.	Filler	1	149	149		
39.	Phone	7	150	156	C	
40.	Filler	1	157	157		
41.	Recipient Last name	17	158	174	C	
42.	Filler	1	175	175		
43.	Recipient First name	14	176	189	C	
44.	Filler	1	190	190		
45.	Recipient Middle Initial	1	191	191	C	
46.	Filler	1	192	192		
47.	Payee	25	193	217	C	Head of Household Name
48.	Filler	1	218	218		
49.	Elig Begin Date	8	219	226	C	CCYYMMDD Medicaid Eligibility Begin Date during time frame reported.
50.	Filler	1	227	227		
51.	Elig End Date	8	228	235	C	CCYYMMDD Medicaid Eligibility End

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						Date 99999999 = no end date
52.	Filler	1	236	236		
53.	Birthdate	8	237	244	C	CCYYMMDD
54.	Filler	1	245	245		
55.	Family number	8	246	253	C	Number which ties family members together
56.	Filler	1	254	254		
57.	# of RSP Programs enrolled In	1	255	255	N	Number of special programs recipient is eligible for
58.	Filler	1	256	256		
59.	RSP Program Code 1	4	257	260	C	Table 02 RSP (Recipient Special Program) Codes
60.	Filler	1	261	261		
61.	RSP Provider No 1	6	262	267	C	
62.	Filler	1	268	268		
63.	RSP Provider Board No 1	6	269	274	C	
64.	Filler	1	275	275		
65.	RSP Program 1- eligible date	8	276	283	C	CCYYMMDD
66.	Filler	1	284	284		
67.	RSP Program 1- ineligible date	8	285	292	C	CCYYMMDD 99999999 = no end date
68.	Filler	1	293	293		
69.	RSP Program Code 2	4	294	297	C	Table 02 RSP (Recipient Special Program) Codes
70.	Filler	1	298	299		
71.	RSP Provider No 2	6	299	304	C	
72.	Filler	1	305	305		
73.	RSP Provider Board No 2	6	306	311	C	
74.	Filler	1	312	312		
75.	RSP Program 2- eligible date	8	313	320	C	CCYYMMDD
76.	Filler	1	321	321		
77.	RSP Program 2- ineligible date	8	322	329	C	CCYYMMDD 99999999 = no end date

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
78.	Filler	1	330	330		
79.	RSP Program Code 3	4	331	334	C	Table 02 RSP (Recipient Special Program) Codes
80.	Filler	1	335	335		
81.	RSP Provider No 3	6	336	341	C	
82.	Filler	1	342	342		
83.	RSP Provider Board No 3	6	343	348	C	
84.	Filler	1	349	349		
85.	RSP Program 3- eligible date	8	350	357	C	CCYYMMDD
86.	Filler	1	358	358		
87.	RSP Program 3- ineligible date	8	359	366	C	CCYYMMDD 99999999 = no end date
88.	Filler	1	367	367		
89.	RSP Program Code 4	4	368	371	C	Table 02 RSP (Recipient Special Program) Codes
90.	Filler	1	372	372		
91.	RSP Provider No 4	6	373	378	C	
92.	Filler	1	379	379		
93.	RSP Provider Board No 4	6	380	385	C	
94.	Filler	1	386	386		
95.	RSP Program 4- eligible date	8	387	394	C	CCYYMMDD
96.	Filler	1	395	395		
97.	RSP Program 4- ineligible date	8	396	403	C	CCYYMMDD 99999999 = no end date
98.	Filler	1	404	404		
99.	RSP Program Code 5	4	405	408	C	Table 02 RSP (Recipient Special Program) Codes
100	Filler	1	409	409		
101	RSP Provider No 5	6	410	415	C	
102	Filler	1	416	416		
103	RSP Provider Board No 5	6	417	422	C	
104	Filler	1	423	423		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
105	RSP Program 5- eligible date	8	424	431	C	CCYYMMDD
106	Filler	1	432	432		
107	RSP Program 5- ineligible date	8	433	440	C	CCYYMMDD 99999999 = no end date
108	Filler	1	441	441		
109	MHN Board number	6	442	447	C	Not applicable for possible recipient file. MHN Board for sure file.
110	Filler	1	448	448		
111	Medicare Eligibility Switch	1	449	449	C	M = Medicare and Medicaid Eligible (dual) X = Only Medicaid Eligible
112	Filler	1	450	450		
113	Language Indicator	3	451	453	C	Table 21 – Language Codes
114	Filler	1	454	454		
115	Race Code-834 Compliant	1	455	455	C	Table 22 – 834 Compliant Race Codes
116	Filler	5	456	460		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MCO/MHN Recipient Review Recertification File

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last,First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		
17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD
20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST-NAME	17	183	199	C	
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST-NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE-EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

Note 1: Payee Types for Field 27.
SEL SELF OR AFDC PAYEE
GDN LEGAL GUARDIAN
REL OTHER RELATIVE
AGY SOCIAL AGENCY
PPP PROTECTIVE PAYEE
REP REPRESENTATIVE PAYEE
FOS INDICATES FOSTER CHILD
SPO SPOUSE
INP LEGALLY INCOMPETENT, NO REPRESENT

Note 1: Payment Categories for Field 29.
10 MAO (NURSING HOMES)
11 MAO (EXTENDED TRANSITIONAL)
12 OCWI (INFANTS UP TO AGE 1)
13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14 MAO (GENERAL HOSPITAL)
15 MAO (CLTC)
16 PASS-ALONG ELIGIBLES
17 EARLY WIDOWS/WIDOWERS
18 DISABLED WIDOWS/WIDOWERS
19 DISABLED ADULT CHILD
20 PASS ALONG CHILDREN
30 AFDC (FAMILY INDEPENDENCE)
31 TITLE IV-E FOSTER CARE

32 AGED, BLIND, DISABLED
33 ABD NURSING HOME
40 WORKING DISABLED
41 MEDICAID REINSTATEMENT
48 S2 SLMB
49 S3 SLMB
50 QUALIFIED WORKING DISABLED (QWDI)
51 TITLE IV-E ADOPTION ASSISTANCE
52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)
53 NOT CURRENTLY BEING USED
54 SSI NURSING HOMES
55 FAMILY PLANNING
56 COSY/ISCEDC
57 KATIE BECKETT CHILDREN - TEFRA
58 FI-MAO (TEMP ASSIST FOR NEEDY)
59 LOW INCOME FAMILIES
60 REGULAR FOSTER CARE
68 FI-MAO WORK SUPPLEMENTATION
70 REFUGEE ENTRANT
71 BREAST AND CERVICAL CANCER
80 SSI
81 SSI WITH ESSENTIAL SPOUSE
85 OPTIONAL SUPPLMENT
86 SUPPLEMENT & SSI
87 OCWI (PREGNANT)
88 OCWI (CHILD UP TO 19)
90 MEDICARE BENE(QMB)
91 RIBICOFF CHILDREN
92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL HOMES NETWORK
RECORD DESCRIPTION
REFERENCE FILES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
	FILE 1 Procedure Code File				**MHN0225.FILE1.PROCEDUR.CODE**
1	PROCEDURE CODE SUBFILE	1	1	1	See Table 6, Procedure Code Subfile
2	PROCEDURE CODE	5	2	6	
3	CODE DESCRIPTION	40	7	46	
4	EFFECTIVE DATE	8	47	54	CCYYMMDD
5	FILLER (reserved for future use)	6	55	60	
	FILE 2 Diagnosis Code File				**MHN0225.FILE2.DIAGNOS.CODE**
1	DIAGNOSIS CODE	6	1	6	
2	CODE DESCRIPTION	40	7	46	
3	DIAGNOSIS CODE CLASS	1	47	47	A CANCER B ACCIDENT C PSYCHIATRIC D COMPLICATED PREGNANCY E NON-COMPLIC PREGNANCY F SPEECH 0 NON-COVERED 1 NO CLASSIFICATION 2 CODE EXPANDED
4	FILLER (reserved for future use)	3	48	50	
	FILE 3 Fund Code File				**MHN0225.FILE3.FUNDCODE**
1	FUND CODE	2	1	2	
2	CODE DESCRIPTION	23	3	25	
3	FILLER (reserved for future use)	5	26	30	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
	FILE 4 Provider File				**MHN0225.FILE4.PROVIDER**
1	PROVIDER NUMBER	6	1	6	MEDICAID PROVIDER NUMBER
2	PROVIDER NAME	26	7	32	
3	STREET	26	33	58	
4	CITY	20	59	78	
5	STATE	2	79	80	
6	ZIP	9	81	89	
10	TELEPHONE	10	90	99	
11	FEIN OR SSN NUMBER	9	100	108	
12	PROVIDER TYPE	2	109	110	See table 9, Provider type
13	PROVIDER STATUS	1	111	111	1 ACTIVE ELIGIBLE 2 ACTIVE PRIOR AUTHORIZATION 3 TERMINATED-INVOLUNTARY 4 TERMINATED-VOLUNTARY 5 SUSPENDED-INVOLUNTARY 7 ACTIVE, DO NOT PAY MEDICARE 8 ACTIVE PRIOR AUTHORIZATION, DO NOT PAY MEDICARE 9 ACTIVE, MEDICARE ONLY, DO NOT PAY MEDICAID
14	STATUS DATE	6	112	117	YYMMDD
15	SPECIALTY	2	118	119	See table 10, Provider specialty
16	COUNTY	2	120	121	See table 3, County codes and names
17	SORT	16	122	137	Sort key, generally last name, first name or Business name
18	NPI	10	138	147	Available if present.
19	Filler	3	148	150	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
	FILE 5 NDC Drug Code File				**MHN0225.FILE5.NDC.DRUGCODE**
1	NDC CODE	11	1	11	
2	CODE DESCRIPTION	40	12	51	
3	DRUG CLASS	1	52	52	1 LEGEND 2 LEGEND MULT SRCE 3 OVER-THE-COUNTER 4 OTC MULT SOURCE 5 FED MAC LEG-MS 6 STATE MAC LEG-MS 7 DESI/IRS/LTE
4	THERAPEUTIC CLASS	6	53	58	See Table 19 Drug Therapeutic Class
5	GENERIC CLASS	5	59	63	Table not available, see NDC website
3	FILLER (reserved for future use)	7	64	70	
	FILE 6 DRG Code File				**MHN0225.FILE6.DRGCODE**
1	DRG CODE	3	1	3	
2	CODE DESCRIPTION	40	4	43	
3	FILLER (reserved for future use)	7	44	50	
	FILE 7 Surgical Code File				**MHN0225.FILE7.SURGCODE**
1	SURGICAL CODE	6	1	6	
2	CODE DESCRIPTION	40	7	46	
4	FILLER (reserved for future use)	4	47	50	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
	FILE 8 PROVIDER MEMBERSHIP FILE				**MHN0225.FILE8.PROVIDER.MEMBER**
1	PROVIDER NUMBER	6	1	6	
2	PROVIDER NAME	26	7	32	
3	GROUP PROVIDER NUMBER	6	33	38	
4	GROUP PROVIDER NAME	26	39	64	
5	NATIONAL PROVIDER NUMBER	10	65	75	
6	NATIONAL GROUP PROVIDER #	10	75	85	
7	FILLER	5	85	90	

MCO/MHN/MAXIMUS Sync File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	MCO or MHN Provider Number	06	11	16	C	
3.	Enroll Date	08	17	24	C	Mask - CCYYMMDD
4.	Termination Date	08	25	32	C	Mask – CCYYMMDD Blank or all 9's = open eligibility
5.	PCP Provider Number	6	33	38	C	Valid only for MHN's – preferred physician
6.	Filler	2	39	40	C	
7.	County	2	41	42	C	
8.	Recipient Last Name	17	43	59	C	
9.	Recipient First Name	14	60	73	C	
10.	Middle Initial	1	74	74	C	
11.	Filler	6	75	80		
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

APPENDICES

COUNTY LISTING

01 ABBEVILLE
02 AIKEN
03 ALLENDALE
04 ANDERSON
05 BAMBERG
06 BARNWELL
07 BEAUFORT
08 BERKELEY
09 CALHOUN
10 CHARLESTON
11 CHEROKEE
12 CHESTER
13 CHESTERFIELD
14 CLARENDON
15 COLLETON
16 DARLINGTON
17 DILLON
18 DORCHESTER
19 EDGEFIELD
20 FAIRFIELD
21 FLORENCE
22 GEORGETOWN
23 GREENVILLE
24 GREENWOOD
25 HAMPTON
26 HORRY
27 JASPER
28 KERSHAW
29 LANCASTER
30 LAURENS
31 LEE
32 LEXINGTON
33 MCCORMICK
34 MARION
35 MARLBORO
36 NEWBERRY
37 OCONEE
38 ORANGEBURG
39 PICKENS
40 RICHLAND
41 SALUDA
42 SPARTANBURG
43 SUMTER
44 UNION
45 WILLIAMSBURG
46 YORK
60 Georgia within SC service area
61 Georgia outside SC service area
62 North Carolina within SC service area
63 North Carolina outside SC service area
64 Other

PROVIDER PRACTICE SPECIALTY TABLE

	Provider Specialty Code	Provider Specialty Code Description
	AA	PEDIATRIC SUB-SPECIALIST
	EN	DENTAL - ENDODONTIST
	PE	DENTAL - PERIODONTIST
	00	NO SPECIFIC MEDICAL SPECIALTY
	01	THERAPIST/MULTIPLE SPECIALTY GROUP
	02	ALLERGY AND IMMUNOLOGY
	03	ANESTHESIOLOGY
	04	AUDIOLOGY
	05	CARDIOVASCULAR DISEASES
	06	MIDWIFE
	07	CHIROPRACTIC
	08	DENTISTRY
	09	DERMATOLOGY
	10	EMERGENCY MEDICINE
	11	ENDOCRINOLOGY AND METAB
	12	FAMILY PRACTICE
	13	GASTROENTEROLOGY
	14	GENERAL PRACTICE
	15	GERIATRICS
	16	GYNECOLOGY
	17	HEMATOLOGY
	18	INFECTIOUS DISEASES
	19	INTERNAL MEDICINE
	20	PVT MENTAL HEALTH
	21	NEPHROLOGY/ESRD
	22	NEUROLOGY
	23	NEUROPATHOLOGY
	24	NUCLEAR MEDICINE
	25	NURSE ANESTHETIST
	26	OBSTETRICS
	27	OBSTETRICS AND GYNECOLOGY
	28	SCDMH
	29	OCCUPATIONAL MEDICINE
	30	ONCOLOGY
	31	OPHTHALMOLOGY
	32	OSTEOPATHY
	33	OPTICIAN
	34	OPTOMETRY
	35	ORTHODONTICS
	36	OTORHINOLARYNGOLOGY

	37	HOSPITAL PATHOLOGY
	38	PATHOLOGY
	39	PATHOLOGY, CLINICAL
	40	PEDIATRICS
	41	PEDIATRICS, ALLERGY
	42	PEDIATRICS, CARDIOLOGY
	43	PEDODONTICS
	44	INDEPENDENT LAB - PRICING ONLY
	45	PHYSICAL MEDICINE & REHABILITATION
	46	XRAY - LAB - PRICING ONLY
	47	PODIATRY
	48	PSYCHIATRY
	49	PSYCHIATRY, CHILD
	50	FEDERALLY QUALIFIED HEALTH CLINICS
	51	DHEC
	52	PULMONARY MEDICINE
	53	NEONATOLOGY
	54	RADIOLOGY
	55	RADIOLOGY, DIAGNOSTIC
	56	RADIOLOGY, THERAPEUTIC
	57	RHEUMATOLOGY
	58	FEDERALLY FUNDED HEALTH CLINICS (FF
	59	SUPPLIER (DME)
	60	HOME HEALTH - PRICING ONLY
	61	SURGERY, CARDIOVASCULAR
	62	SURGERY, COLON AND RECTAL
	63	SURGERY, GENERAL
	64	AMBULANCE - PRICING ONLY
	65	SURGERY, NEUROLOGICAL
	66	SURGERY, ORAL (DENTAL ONLY)
	67	SURGERY, ORTHOPEDIC
	68	SURGERY, PEDIATRIC
	69	SURGERY, PLASTIC
	70	SURGERY, THORACIC
	71	SURGERY, UROLOGICAL
	72	CLINIC SCREENERS - PRICING ONLY
	73	PHYSICIAN SCREENERS - PRICING ONLY
	74	PROSTHETICS & ORTHOTICS PRICE ONLY
	75	INDIVIDUAL TRANS - PRICING ONLY
	76	CAP - PRICING ONLY
	77	CLTC
	78	MULTIPLE SPECIALTY GROUP
	79	CLTC - ALTERNATE
	80	OUTPATIENT-PRICING ONLY
	81	OUTPATIENT-ALTERNATE PRICING SPECIA
	82	PSYCHOLOGIST
	83	SOCIAL WORKER
	84	SPEECH THERAPIST

	85	PHYSICAL/OCCUPATIONAL THERAPIST
	86	NURSE PRACTITIONER
	87	OCCUPATIONAL THERAPIST
	88	HOSPICE
	89	CORF
	90	ALCOHOL & DRUG ABUSE
	91	MENTAL RETARDATION
	92	SED CHILDREN
	93	AMBULATORY SURGERY
	94	DIABETES EDUCATOR
	95	DEVELOPMENTAL REHABILITATION
	96	FAMILY PLANNING, MATERNAL & CHILD H
	97	RURAL HEALTH CLINICS (RHC)
	98	PRIVATE DUTY NURSING
	99	PEDIATRIC NURSE PRACTITIONER

BILLS OF RIGHTS

MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness or medical condition.
- To receive all information—enrollment notices, informational materials, instructional materials, available treatment options and alternatives, etc.—in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and the Contractor in understanding the requirements and benefits of the MHN plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the Contractor's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the Contractor's services, to include, but not limited to:

    - Benefits covered.
    - Procedures for obtaining benefits, including any authorization requirements.
    - Any cost sharing requirements.
    - Service area.
    - Names, locations, telephone numbers of any non-English language spoken by current contracted providers, including, at a minimum, primary care physicians, specialists, and hospitals.
    - Any restrictions on member's freedom of choice among network providers.
    - Providers not accepting new patients.

    - Benefits not offered by the Contractor but available to members and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services and post-stabilization services.
    - That Emergency Services do not require prior authorization.
    - The process and procedures for obtaining Emergency services.
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services.
    - Member's right to use any hospital or other setting for emergency care.
    - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).
- To receive the Contractor's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the Contractor, its providers or SCDHHS treat the member.

PROVIDERS' BILL OF RIGHTS

Each Health Care Provider who contracts with SCDHHS and with the local Medical Homes Network to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
    - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
    - Any information the member needs in order to decide among all relevant treatment options.
    - The risks, benefits and consequences of treatment or non treatment.
    - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To have access to the Network's policies and procedures covering the authorization of services.
- To be notified of any decision by the Network to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- To challenge, on behalf of the Medicaid members, the denial of coverage of, or payment for medical assistance.
- The Network's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification

FORMS

Plan Initiated Disenrollment Request

The member(s) listed below is to be disenrolled from the following plan_____ for the reason listed below. Please check all that apply.

- ☐ Member demonstrates a pattern of disruptive abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;
- ☐ Member's utilization of services is fraudulent or abusive;
- ☐ Member is in a long-term care nursing facility beyond (30) calendar days;
- ☐ Member is placed in an intermediate care facility for the mentally retarded (ICF/MR);
- ☐ Member moved out of the service area and plan does not operate in the new service area;
- ☐ Member has died or is incarcerated.
- ☐ Other _____

Print the Name of Member to be Disenrolled (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

Address c/o _____ Street _____ City/State/Zip _____	Phone Number (_____) _____ County _____

Signature: _____ Date: _____

_____

The South Carolina Department of Health and Human Services will determine if the Health Plan has shown a good cause to disenroll the Medicaid member. The Health Plan Liaison will give written notification to the Health Plan of the decision. Medicaid members have the right to appeal enrollment and disenrollment decisions with the South Carolina Department of Health and Human Services.

The Health Plan shall not discriminate against any Medicaid member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

Mail completed form to: South Carolina Healthy Connections Choices
Attn: Larissa Hendley
140 Stoneridge Drive, Suite 385
Columbia, SC 29210

FROM (Provider name and address):	TO: (SCDHHS Medicaid Eligibility)

IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER

A. MOTHER:

Name: _____

Address: _____ _____

Social Security Number: _____ Date of Birth: _____ _____

Were parental rights terminated prior to delivery? ___ Yes ___ No
Did the mother have a permanent sterilization procedure? __Yes __No

Medicaid ID Number: _____ County: _____

Medicaid Eligibility Worker Name (if known): _____

B. CHILD:

Name: _____

Date of Birth: _____ Race: _____ Sex: _____

Has application been made for a SSN for the child? ___Yes ___No

Provider representative furnishing information: _____ ___

Telephone number: _____ Date: _____ ___

MEDICAID ELIGIBILITY INFORMATION FURNISHED BY SCDHHS
(Within 5 working days)

Child's Medicaid ID Number: _____ __

Effective date of Eligibility: _____ ___

Medicaid Eligibility Worker: _____ Date: _____

Location:_____ Telephone number: _____

SCDHHS Form 1716 ME (Sept 2002)

WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation. .

Name of Person being referred: _____

Address: _____

Phone: _____

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

____ Pregnant woman

____ Woman who is breast feeding her infant(s) up to one year postpartum

____ Woman who is non-breast feeding up to six months postpartum

____ Infant (age 0-1)

____ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

Provider's Name: _____

Provider's Phone: _____

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to:

WIC Program Contact
Address
Phone Number

MEDICAL RECORD RELEASE

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

Signature _____
(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)

Date _____

MEDICAL HOMES NETWORK

SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206, Phone (803) 898-2818

South Carolina MHN Hospital Admission Agreement/Formal Arrangement

This form is to be completed in lieu of having hospital admitting privileges.

SC MHN Primary Care Provider Applicant

(First Party Section)

Applicant Name:_____ Provider Number: _____

Group Name: _____

Mailing Address: _____

To ensure a complete understanding between both parties and continuity of coverage among providers, SC MHN has adapted the SC MHN Patient Admission Agreement/Formal Arrangement Form. This form serves as a formal written agreement established between the above parties for the following:

- The SC MHN Primary Care Provider is privileged to refer adult/pediatric and Emergency patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for SC MHN member admissions during his/her vacation.
- This agreement may be terminated by either of the parties at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The SC MHN Primary Care Provider will notify SC MHN in writing of any changes/terminations to this agreement.
- The SC MHN Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above SCMHN Provider Applicant:

(Second Party Section)

Physician/Group Name: _____

Mailing Address: _____

_____ Phone Number: _____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

_____

Signature: _____ Date: _____

<<Name of Network>> COMPLAINT FORM

**Note: For reporting complaints regarding MHN Providers ONLY*

Mail the completed, ***signed*** form to: Network Office
Street Address or PO Box
City, State, Zip code

Name of Person Completing this Form: _____
(may be MHN member, designated friend/family member, medical provider, hospital, community member, etc.)

Relationship to Member: _____ Date Form Completed: _____

MHN Member Name: _____ DOB: _____

Medicaid ID:_____ County of Residence: _____

Address: _____

Telephone Number: _____

Name of Doctor: _____

Practice: _____

Please describe your complaint in detail including dates/names. Please attach any additional documentation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Over (See Consent Statement and Signature)

continued

SC MHN COMPLAINT FORM

(page 2)

<<Name of Network>> staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place for addressing each one. It is not necessary for us to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **Please do not sign both statements.**

1. **If you agree to allow us to use your name in investigating this complaint, please sign the following:**

I give the SC MHN Managed Care staff permission to use my name when sharing my complaint with the Primary Care Provider (PCP) named in my complaint. The PCP has my permission to respond to the SCMHN staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date of Birth

OR

2. **If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:**

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date of Birth

If you have any questions regarding the use of this form or the MHN Complaint Process, please contact the <<Name of Network>> office at <<insert telephone number>>. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

MHN PCP Name: _____ MHN PCP#: _____

MHN Practice Name: _____ Location: _____

Comments: _____

_____

DEFINITION OF TERMS

DEFINITION OF TERMS

The following terms, as used in this Guide, shall be construed and interpreted as follows unless the context clearly requires otherwise.

Action – A termination, suspension or reduction (which includes denial of a service based on Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services. It further means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

AFDC/Family Independence - Aid to Families with Dependent Children.

Applicant - An individual seeking Medicaid eligibility through written application.

Beneficiary - An individual who is Medicaid eligible and meets the criteria to enroll in the Medical Homes Network Managed Care or Organization program.

CFR - Code of Federal Regulations.

CPT-4 - Current Procedural Terminology, fourth edition.

Care Coordination - The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MHN Program members.

Care Coordinator - The individual responsible for planning, directing and coordinating services to meet identified health care needs of Medicaid MHN Program members.

Care Coordination Fee – The amount paid to the Contractor per member per month (PMPM) for each MHN member who has chosen the Contractor.

Care Coordination Services Organization (CSO)– CSO shall be used to describe the entity providing the infrastructure to the Medical Homes Network It is an experienced, responsive, responsible and financially sound organization that provides infrastructure and support to the Network and the participating primary care practices.

Case - A household consisting of one or more Medicaid beneficiaries.

Case Manager - The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid MHN Program members.

Certificate of Coverage - The term that describes services and supplies provided to Medicaid MHN program member, which includes specific information on benefits, coverage limitations and services not covered. The term "certificate of coverage" is interchangeable with the term "evidence of coverage".

CMS – Centers for Medicare and Medicaid Services

Co-payment - Any cost-sharing payment for which the Medicaid MHN Program member is responsible for in accordance with 42 CFR 447.50.

Core Benefits - A schedule of health care benefits provided to Medicaid MHN Program members enrolled in the Contractor's plan as specified under the terms of the MHN contract.

Covered Services - Services included in the South Carolina State Medicaid Plan.

DHEC - Department of Health and Environmental Control.

Disease Management – Activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management.

Disenrollment - Action taken by SCDHHS or its designee to remove a Medicaid MHN Program member from the Contractor's plan following the receipt and approval of a written request for disenrollment or a determination made by SCDHHS or its designee that the member is no longer eligible for Medicaid or the Medicaid MHN Program.

Documented Cost Savings – Those cost savings verified by SCDHHS by using an independent actuary to establish the baseline and to conduct periodic reconciliation during the Contract period. The difference between the Medicaid Upper Payment Limit of the Medical Homes Network enrollees as defined/calculated in this Policy and Procedure Guide and the total amount of covered claim expenditures incurred by Medical Homes Network enrollees (including the prospective per member per month case management/care coordination fee payments) during the contract period.

Dual Eligibles - Applicants that receive Medicaid and Medicare benefits.

EPSDT - The Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

Eligible(s) - A person who has been determined eligible to receive services as provided for in the Title XIX SC State Medicaid Plan.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn

child) in serious jeopardy; serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition.

Enrollee – A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

Enrollment - The process in which an applicant/beneficiary selects a Contractor and goes through an educational process to become a Medicaid **MHN** Program member of the Contractor.

Evidence of Coverage - The term which describes services and supplies provided to Medicaid **MHN** Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "evidence of coverage" is interchangeable with the term "certificate of coverage".

FPL - Federal Poverty Level.

FFP - Federal Financial Participation. Any funds, either title or grant, from the Federal Government.

FTE - A full time equivalent position.

Family Planning Services - Services that include examinations and assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Federally Qualified Health Center/FQHC - A South Carolina licensed health center that is certified by the Centers for Medicare and Medicaid Services and receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a medically under-served area.

Fee-for-Service (FFS) Medicaid Rate - A method of making payment for health care services based on the current Medicaid fee schedule.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself of some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Health Care Professional – A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, Physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist and certified respiratory therapy technician.

HCPCS - CMS's Common Procedure Coding System.

HEDIS - Health Plan Employer Data and Information Set. Standards for the measures are set by the NCQA.

ICD-9 - International Classification of Disease, 9th Edition, 2008..

Inquiry – A routine question/s about a benefit. An inquiry does not automatically invoke a plan sponsor's grievance or coverage determination process.

Insolvency - A financial condition in which a MHN's assets are not sufficient to discharge all its liabilities or when the MHN is unable to pay its debts as they become due in the usual course of business.

MMIS - Medicaid Management Information System.

Managed Care Organization – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is—(1) A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR § 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area service by the entity; and (b) Meets the solvency standards of 42CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.

Managed Care Plan - The term "Managed Care Plan" is interchangeable with the terms "Contractor", "Plan", or "HMO/MCO/MHN".

Marketing – Any communication approved by SCDHHS, from a MHN/MCO to a Medicaid beneficiary who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the beneficiary to enroll in that particular MHN/MCO Medicaid product, or either to not enroll, or to disenroll from, another MHN/MCO Medicaid product.

Marketing Materials – Materials that (1) are produced in any means, by or on behalf of an MHN and (2) can be reasonable interpreted as intended to market to potential members.

Mass Media - A method of public advertising that can create plan name recognition among a large number of Medicaid beneficiaries and can assist in educating them about potential health care choices. Examples of mass media are internet sites, radio spots, television advertisements, newspaper advertisements, newsletters and video in doctor's office waiting rooms.

Medicaid - The medical assistance program authorized by Title XIX of the Social Security Act.

Medicaid Provider - An institution, facility, agency, person, corporation, partnership or association approved by SCDHHS which accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medical Homes Networks (MHN) - A group of physicians, who have agreed to serve as Primary Care Case Management (PCCM) providers, and other health care providers who partner with an Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and for managing members' care.

Medicare - A federal health insurance program for people 65 or older and certain individuals with disabilities.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the MHN, its subcontractor or any out of plan providers.

Medically Necessary Service - Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in illness or infirmity of a Medicaid MHN Program member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of Medicaid MHN Program a member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Member or Medicaid MHN Program Member - An eligible person who has enrolled with aMedical Home Network program.

NCQA – The National Committee for Quality Assurance is a private, non-for-profit organization founded in 1990, which sets Medicare, Medicaid, and private insurance HEDIS measurements. They have accreditation and certification programs for a different types of health providers and health assessment products.

NDC - National Drug Code.

National Practitioner Data Bank - A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

Newborn - A live child born to a member during her membership or otherwise eligible for enrollment under the Contract.

Non-Contract Provider - Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by the MHN to provide health care services.

Non-Covered Services - Services not covered under the Title XIX SC State Medicaid Plan.

Non-Emergency - An encounter by a Medicaid MHN Program member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

Non-Participating Physician - A physician licensed to practice who has not contracted with or is not employed by the **MHN** to provide health care services.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the MCO. For further definition see 42 CFR 455.101 (1992).

Plan - The term "Plan" is interchangeable with the terms "Contractor," “Medical Homes Network Program,” or “MHN,”

Policies - The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and by state federal rules and regulations.

Post-Stabilization Services - Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve or resolve the member’s condition.

Primary Care – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management – A system under which a Primary Care Case Manager contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

Primary Care Case Manager (PCCM) – A physician, a physician group practice or an entity that employs or arranges with physicians to furnish primary care case management services to Medicaid beneficiaries.

Primary Care Physician (PCP) - An individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews. The provider serves as the entry point into the health care system for the member. The PCP is responsible for including, but not limited to the providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services and maintaining the continuity of care.

Prior Authorization (PA) - The act of authorizing specific approved services, by the MHN or PCP, before they are rendered.

Program - The method of provision of Title XIX services to South Carolina beneficiaries as provided for in the Title XIX SC State Medicaid Plan and SCDHHS regulations.

Provider –Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Managed Care Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Quality – As it pertains to external quality review, means the degree to which an MHN increases the likelihood of desire health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assurance - The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available and medically necessary.

Recipient - A person who is determined eligible in receiving services as provided for in the Title XIX SC State Medicaid Plan.

Referral Services - Health care services provided to Medicaid MHN Program members outside the MHN's designated facilities or its subcontractors when ordered and approved by the MHN.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another.

Rural Health Clinic/RHC - A South Carolina licensed rural health clinic that is certified by the CMS and receives Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically under-served area.

Routine Care - Is treatment of a condition which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

SCDOI - South Carolina Department of Insurance.

SCDHHS - South Carolina Department of Health and Human Services

SCDHHS Appeal Regulations - Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Regs. 126-150 et seq. and S.C. Code Ann. §§1-23-310 et seq. (1976, as amended).

Service Area - The geographic area in which the MHN is authorized to accept enrollment of eligible Medicaid Program members into the MHN plan. The service area must be approved by SCDHHS.

Service Referral Management – A process of issuing referrals by the MHN to allow for specialty care provision, in order to facilitate monitoring the appropriateness of care.

SSA - Social Security Administration.

SSI - Supplemental Security Income.

Screen or Screening - Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

Social Security Act - Title 42, United States Code, Chapter 7, as amended.

Social Services - Medical assistance, rehabilitation and other services defined by Title XIX, SCDHHS regulations, and SCDHHS regulations.

South Carolina State Plan for Medical Assistance - A plan, approved by the Secretary of SCDHHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to beneficiaries pursuant to Title XIX.

Subcontract - A written Contract agreement between the MHN and a third party to perform a specified part of the Contractor's obligations as specified under the terms of the SCDHHS MHN Contract.

Subcontractor - Any organization or person who provides any functions or service for the MHN specifically related to securing or fulfilling the MHN's obligations to SCDHHS under the terms of this Contract.

Termination - The member's loss of eligibility for the S.C. Medicaid MH**N** Program and therefore automatic disenrollment from the MHN's plan.

Title XIX - Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. § 1396 et seq.)

Urgent Care - Medical conditions that require attention within forty eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

Validation – The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Well Care - A routine medical visit for one of the following: EPSDT visit, family planning, routine follow-up to a previously treated condition or illness, adult and/or any other routine visit for other than the treatment of an illness.

WIC - The Supplemental Food Program for Women, Infants and Children which provides nutrition counseling, nutrition education and nutritious foods to pregnant and postpartum women, infants and children up to the age of two or children deemed nutritional deficient are covered up to age five who have a low income and who are determined to be at nutritional risk.